ALABAMA MEDICAID AGENCY

REQUEST FOR PROPOSALS

RFP Number: **2015-MCMS-01**	**RFP Title:** **Alabama Medicaid Agency Maternity Care Program**
RFP Due Date and Time: **August 20, 2015 by 4:00 p.m. Central Time**	**Number of Pages: 82**
PROCUREMENT INFORMATION	
Project Director: **Sylisa Lee-Jackson**	**Issue Date: July 22, 2015**
Phone: 334-353-4599 **E-mail Address: sylisa.lee-jackson@medicaid.alabama.gov** **Website:** **http://www.medicaid.alabama.gov**	**Issuing Division: Managed Care**
INSTRUCTIONS TO VENDORS	
Return Proposal to: **Alabama Medicaid Agency** **Lurleen B. Wallace Building** **501 Dexter Avenue** **PO Box 5624** **Montgomery, AL 36103-5624**	**Mark Face of Envelope/Package:** **RFP Number: 2015-MCMS-01** **RFP Due Date: August 20, 2015 by 4:00 p.m. Central Time** **District Number** **Firm and Fixed Price:**
VENDOR INFORMATION ***(Vendor must complete the following and return with RFP response)***	
Vendor Name/Address:	Authorized Vendor Signatory: (Please print name and sign in ink)
Vendor Phone Number:	Vendor FAX Number:
Vendor Federal I.D. Number:	Vendor E-mail Address:

Section A. RFP Checklist

1. ____ **Read the *entire* document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; licensing requirements; contract requirements (i.e., contract performance security, insurance requirements, performance and/or reporting requirements, etc.).

2. ____ **Note the project director's name, address, phone numbers and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.

3. ____ **Take advantage of the "question and answer" period.** Submit your questions to the project director by the due date(s) listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the State's website and will include all questions asked and answered concerning the RFP.

4. ____ **Use the forms provided**, i.e., cover page, disclosure statement, etc.

5. ____ **Check the State's website for RFP addenda.** It is the Vendor's responsibility to check the State's website at www.medicaid.alabama.gov for any addenda issued for this RFP, no further notification will be provided. Vendors must submit a signed cover sheet for each addendum issued along with your RFP response.

6. ____ **Review and read the RFP document again** to make sure that you have addressed all requirements. Your original response and the requested copies must be identical and be complete. The copies are provided to the evaluation committee members and will be used to score your response.

7. ____ **Submit your response on time.** Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are ***never*** accepted.

8. ____ **Prepare to sign and return the Contract, Contract Review Report, Business Associate Agreement and other documents** to expedite the contract approval process. The selected vendor's contract will have to be reviewed by the State's Contract Review Committee which has strict deadlines for document submission. Failure to submit the signed contract can delay the project start date but will not affect the deliverable date.

This checklist is provided for assistance only and should not be submitted with Vendor's Response.

Section B. Schedule of Events

The Vendor's proposal must contain acknowledgement of the Schedule of Events.

The following RFP Schedule of Events represents the State's best estimate of the schedule that shall be followed. Except for the deadlines associated with the vendor question and answer periods and the proposal due date, the other dates provided in the schedule are estimates and will be impacted by the number of proposals received. The State reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. Notification of any adjustment to the Schedule of Events shall be posted on the RFP website at www.medicaid.alabama.gov.

EVENT	DATE
RFP Issued	7/22/2015
Deadline for questions to be submitted	7/29/2015
Deadline for questions to be posted to website	8/14/2015
Proposals Due by 4:00 pm CST	8/20/2015
Evaluation Period	8/20/2015-9/3/2015
Contract Award Notification	9/30/2015
Contract Review Committee	12/3/2015
Official Contract Award/Begin Work	1/1/2016

* *By State law, this contract must be reviewed by the Legislative Contract Review Oversight Committee. The Committee meets monthly and can, at its discretion, hold a contract for up to forty-five (45) days. The "Vendor Begins Work" date above may be impacted by the timing of the contract submission to the Committee for review and/or by action of the Committee itself.

Table of Contents

I. Background

A. The Alabama Medicaid Agency, hereinafter called Medicaid, an Agency of the State of Alabama, began the Maternity Care Program in 1988 under the authority of a 1915(b) Waiver and State Plan. This authority allows the State to require pregnant women to receive their care through specified networks. The waiver was developed in an effort to address Alabama's high infant mortality rate, the high drop-in delivery rate and the lack of Delivering Healthcare Professionals (DHCP) participation. The waiver is administered statewide in each of the 67 counties, divided into 14 districts **(Figure 1**). The current 1915(b) Waiver will expire on August 30, 2015. Medicaid has requested a waiver renewal.

B. Currently, Medicaid contracts with one administrative entity for each district known as a Primary Contractor. The Primary Contractor, in turn, has the responsibility of establishing a comprehensive network of subcontractors that can provide prenatal, delivery and postpartum care. Medicaid pays for approximately half or 30,000 of all deliveries in the State of Alabama. The Primary Contractor provides methods and procedures to safeguard against unnecessary utilization of care and services to assure efficiency, economy and quality of care as required by law pursuant to section 1902 (a) (30) of the Social Security Act (ACT).

C. The Vendor to whom the contract is awarded shall be responsible for the performance of all duties contained within this Request for Proposal (RFP) for the firm and fixed price quoted in the Vendor's proposal to this RFP. All proposals must state a firm and fixed price for the services described.

D. All information contained in this RFP and any amendments reflect the best and most accurate information available to Medicaid at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for change of the payments to the Contractor or a basis for legal recovery of damages, actual, consequential or punitive, except to the extent that such inaccuracies are the result of intentional misrepresentation by Medicaid.

Figure 1. Districts and Counties Served

District	Counties Served
District 1	Colbert, Franklin, Lauderdale, Marion
District 2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
District 3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
District 4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
District 5	Blount, Chilton, Cullman, Jefferson, St. Clair, Shelby, Walker, Winston

District 6	Clay, Coosa, Randolph, Talladega, Tallapoosa
District 7	Greene, Hale
District 8	Choctaw, Marengo, Sumter
District 9	Dallas, Perry, Wilcox
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
District 11	Barbour, Chambers, Lee, Macon, Russell
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
District 13	Coffee, Dale, Geneva, Henry and Houston
District 14	Mobile

II. Scope of Work

The Vendor's proposal must present a plan to describe how (i.e., draft policies and procedures, or documents deemed necessary) it will meet each of the following requirements listed below.

A. STANDARDS

1. Exhibit a capacity to serve the pregnant Medicaid population in the designated geographical area.

2. Procure a network of subcontractors within 50 miles of all areas in their district. A GPS mapping attachment is required to support this requirement. This is determined through the RFP evaluation process using Letter of Intent to Contract (Attachment Four-A of the Maternity Care Program Operational Manual) from all subcontractors which must list sites where they are located.

3. Designate a full time Director for the district(s) who has the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to the Federal and State regulations. This full time Director may simultaneously assume the directorship position of more than one district. This full time Director must participate in all monthly status calls, attend all called meetings by the Medicaid including, but not limited to, the annual face to face meeting.

4. Establish business hours for the provision of maternity services. The Director or an appropriately qualified designee must be available/accessible, and on call 24 hours a day, 7 days a week for any administrative and/or medical problems which may arise.

5. Require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.

6. Require that all persons, including employees, agents, and subcontractors acting for or on behalf of the Vendor, be properly licensed under applicable State laws and/or regulations.

7. Comply with certification and licensing laws and regulations applicable to the Vendor's practice, profession or business. The Vendor agrees to perform services consistent with the customary standards of practice and ethics in the medical profession.

8. Not knowingly employ or subcontract with any health provider whose participation in the Medicaid and/or Medicare Program, or SCHIP is currently suspended or has been terminated by Medicaid and/or Medicare or SCHIP. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP except for emergency services.

9. Comply with State and Federal laws regarding excluded Individuals and Entities. Excluded individuals and Entitles are not allowed to receive reimbursement for providing Medicare and Medicaid services in any capacity, even if they are not on Medicaid's Exclusion List.

10. Ensure that the subcontractor or Vendor is not currently debarred from participation from Medicare/Medicaid programs by checking the System for Award Management formerly Excluded Party List System (EPLS).

11. Comply with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) on a monthly basis to determine if any existing employee or Vendor has been excluded from participation in the Medicaid program.

12. Ensure subcontractors are complying with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) on a monthly basis to determine if any existing employee or affiliated entities have not been excluded from participation in the Medicaid program.

13. Require network providers offer hours of operation to Medicaid recipients that are not less than the hours of operation to other recipients.

14. Comply with all State and Federal regulations regarding family planning services, including that an enrollee will not be restricted in freedom of choice of providers of family planning services.

15. Comply with State and Federal enrollment requirements and enroll as a Medicaid provider as applicable.

16. Require subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable.

17. Report suspected fraud and abuse to Medicaid. The report must include the number of complaints of fraud and abuse made to the Vendor that warrant an investigation. If an investigation is warranted, the Vendor must supply the name, identification number, source of the complaint, type of provider, nature of complaint, approximate dollars involved and legal and administrative disposition of the case.

18. Prohibit discrimination against recipients based on health status or need for health services.

19. Comply with the requirements of 42 CFR 438.224 in confidentially handling health and enrollment information.

20. Comply with the requirements of 42 CFR Part 438.

21. Comply with the applicable requirements of Alabama Medicaid Administrative Code, 560-X-37 and 560-X-45 and any revisions thereof.

22. Comply with the requirements of the 1915 (b) Maternity Care Waiver and amendments thereof.

23. Comply with the applicable requirements of the Alabama Medicaid Provider Manual and any revisions thereof.

24. Comply with the requirements of the Maternity Care Program Operational Manual and any revisions thereof.

25. The Vendor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a) (2). If the Vendor elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

    a. to the State;

    b. with its application for a Medicaid contract;

    c. whenever it adopts such policy during the term of the contract; and

    d. it must be consistent with the provisions of 42 C.F.R. 438.10;

    e. it must be provided to potential enrollees before and during enrollment; and

    f. it must be provided to enrollees within 90 days after adopting the

policy with respect to any particular service.

26. Comply with the provisions of the American Recovery and Reinvestment Act of 2009, Section 5006, regarding the protections for Indians receiving Medicaid benefits.

27. Comply with the State's provisions for collecting and reporting encounter data as outlined in the Maternity Care Program Operational Manual, Section VIII.E, Payment of Services, Encounter Data, Provider Manual and the Companion Guides.

28. Comply with all financial audits conducted by Medicaid or its appointed authority.

29. Neither the Vendor nor any person, firm or corporation employed by the Vendor in the performance of this contract shall offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation or contract for future reward or compensation at any time during the term of this contract.

B. ADMINISTRATIVE REQUIREMENTS

The Vendor's proposal must present a plan to demonstrate/describe its ability to meet the following requirements. The plan must include a resume for the Director.

Each District must have a full time Director. This person shall have the following minimum qualifications:

1. A BS or BA degree from an accredited college or, or a minimum of three years of management experience in managed health care.

2. Experience in working with low-income populations.

Any changes in the Director's position must be approved by Medicaid. Medicaid must be notified in writing prior to the effective date of the change.

C. FUNCTIONS/RESPONSIBILITIES

The Vendor's proposal must present a plan (i.e., draft policies and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

1. Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts. The successful Vendor's delivery system will not include the hospital component. The hospital will be outside of the global reimbursement for maternity care.

2. Implement and maintain a Medicaid approved quality assurance improvement system by which program access, process and outcomes are measured.

3. Provide Application Assister services to Medicaid recipients utilizing individuals with up-to-date certification as Application Assisters.

4. Utilize proper tools and service planning for women assessed to be at risk medically or psychosocially.

5. Provide recipient choice among DHCPs.

6. Meet all requirements of the provider network, including but not limited to, maintaining written subcontracts, notifying Medicaid of any changes in the network, and maintaining a network of providers to meet program requirements.

7. Maintain a toll-free line and adequate staff to enroll recipients and provide program information. If the Vendor, subcontractors and recipients are within the local calling distance area a toll-free line is not necessary.

8. Develop, implement and maintain an extensive recipient education plan. Documentation must support requirements are met.

9. Develop, implement and maintain a provider education plan. Documentation must support requirements are met.

10. Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Maternity Care Program and the services offered. Documentation must support requirements are met.

11. Develop, implement and maintain an educational program explaining how to access the Maternity Care Program including service locations. Documentation must support requirements are met.

12. Develop, implement and maintain a grievance procedure that is easily accessible and that is explained to recipients upon entry into the system. Documentation must support requirements are met.

13. Develop, and implement a system for accommodating recipient transfer requests that may occur as a result of a grievance or complaint so that care provided by the transferring Delivering Healthcare Professional as well as the receiving Delivering Healthcare Professional my receive payment for services rendered.

14. Develop, implement and maintain a system for handling billing inquiries

from recipients and subcontractors so that inquiries are handled in a timely manner.

15. Maintain a computer based data system that collects, integrates, analyzes and reports recipient information.

16. Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Vendor by any subcontractor which may result in litigation related in any way to this contract. In the event of the filing of a petition for bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Vendor must ensure that all tasks related to any subcontractor are performed in accordance with the Terms of the Agreement.

17. Ensure the subcontractor maintain for each recipient a complete record, including care coordination notes, at one location of all services provided. Such information shall be accessible to the Vendor and shall obtain such information from all providers of services and identify by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of service. Any record requested by the Vendor or Medicaid shall be provided free of charge.

18. Provide copies of medical record documentation to Medicaid, as requested, for medical record reviews and other quality related activities. The Vendor must comply with the applicable provisions of the utilization control requirements of 42 C.F.R. 456, Subpart C.

19. Perform claim review prior to submission to Medicaid for administrative review.

20. Advise recipients of services that may be covered by Medicaid that are not covered through the Maternity Care Program.

21. Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

22. Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee. If the Vendor is unable to provide the necessary care covered under this contract, the Vendor must adequately and timely cover these services out of network for the enrollee with the exception of an exemption granted by the Medicaid. The exemption would be paid fee for service.

23. Use the Medicaid Web Service Database for reporting program demographics and other elements related to the pregnancy.

24. Designate a person to enter data and manage Medicaid's Service Database entries. This designee is responsible for the transmission of valid, timely, complete and comprehensive data, along with auditing the database periodically. The designated representative(s) shall evaluate data for quantitative integrity, such as variances compared to the eligibility system and Service Report omissions. Other responsibilities include, but are not limited to, ensuring that all recipients, excluding exemptions, are entered into the database with all required reporting elements, and correcting discrepancies to ensure an error rate of no greater than 5%. This person must attend mandatory training as designated by the Medicaid.

25. Coordinate service database data entries for recipients transferring from one district to another district to ensure transmission of valid, timely, complete and comprehensive data entries.

D. MATERNITY CARE PROGRAM GUIDELINES

Recipient Served/ Not Served by the Vendor

The Vendor's proposal must include an "acknowledgement and comply" statement regarding the following Maternity Care Program guidelines:

1. Recipients are notified at the time of Medicaid application of the requirement to participate and enrolled in the program. The Vendor must have an outreach plan in their district to inform women of program requirements.

    a. The Vendor must serve the following Medicaid recipients who are pregnant and who are required to participate in the Maternity Care Program:

        i. Those certified under the Affordable Care Act using the Modified Adjusted Gross Income (MAGI) rules for pregnant women with the exception of the Department of Youth Services recipients identified with County Code 69.

        ii. Those certified through the Parent Other Caretaker Relative (POCR)

        iii. Refugees

        iv. Supplemental Security Income (SSI) eligible women

    b. The following Medicaid recipients are not required to participate and should not be enrolled:

        i. Dual eligible (Medicare/Medicaid)

        ii. Individuals granted emergency Medicaid due to their non-citizen

status

2. Subcontracts

a. The Vendor shall not assign a contract without written consent of Medicaid.

b. The Vendor may subcontract for the professional services necessary for the completion and maintenance of this contract and for the performance of its duties under this contract with advance written approval of both the subcontracted function and the subcontractor by Medicaid. Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to the requirements of the contract relevant to the service to be performed. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this RFP.

c. The Vendor shall at all times remain responsible for the performance by subcontractors approved by Medicaid.

d. The Vendor's performance guarantee and responsibility for damages shall apply whether performance or non-performance was by the Vendor or one of its subcontractors.

e. Medicaid shall not release the Vendor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of Vendor, even if such subcontractor was approved by Medicaid as provided above.

f. The Vendor shall give Medicaid notice in writing by registered mail of any action or suit made against said Vendor by any subcontractor or vendor, which, in the opinion of Vendor, may result in litigation related in any way to this contract with the State of Alabama.

g. The Vendor must submit Letters of Intent to Contract (Attachment Four-A of the Maternity Care Operational Manual) from each subcontractor, if the use of subcontractors is necessary to meet the requirements of this RFP. The Letters of Intent to Contract must be signed by an individual authorized to legally bind the subcontractor to perform the scope of work as assigned, stating:

    i. The general scope and volume of work to be performed by the subcontractor.

    ii. The subcontractor's willingness to perform the work indicated.

    iii. The names and titles of individuals who will be responsible for the subcontractor's efforts.

iv. The rate or methodology (if a varying rate is to be paid) of reimbursement to be received for the subcontractor's efforts.

h. The Vendor shall comply with Title VI of the Civil Rights Act of 1964 42 USC §2000d, et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC §6101, et seq.) and the Americans with Disabilities Act of 1990 (42 USC §2101, et seq.), and the regulations issued there under by the Department of Health and Human Services (45 CFR Parts 80, 84 and 90). No individual shall, on the ground of race, sex, color, creed, national origin, age or disability be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program of services.

E. HEALTHCARE PROFESSIONALS

The Vendor's proposal must present a plan (i.e., draft policies and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

Provider Network

a. The Vendor must have a delivery system that meets Medicaid standards and that promotes continuity of care and quality care. Vendor must ensure that all medically necessary services, included as covered services pursuant to this proposal, are provided. The proposal must contain documentation that the Vendor has a provider network in place.

b. The Vendor must offer participation opportunities for 30 days prior to the contract start date and for the first month of each succeeding contract year to all interested potential subcontractors within district boundaries. Subcontractors must be willing to abide by all program requirements and accept offered reimbursement for services provided. For purposes of offering and awarding subcontracts, Vendor must offer the reimbursement level consistent with other like subcontractors.

c. The Vendor shall not offer participation to potential subcontractors who do not agree to abide by program requirements or to those who have been disqualified from participation in any federal program or any person convicted of an offense involving Medicaid. However, providers who are willing to abide by program requirements must be given equal and fair participation opportunities. Complaints of discrimination will be investigated by Medicaid.

d. The Vendor must contract with subcontractors who are geographically appropriate (50 miles) to recipients within the district.

e. The Vendor must continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid recipients and availability and accessibility are not hindered. The Vendor must submit documentation to the Medicaid when there are changes in services, benefits, geographic service area or payments in order to assure adequate capacity and services.

f. The Vendor must monitor and evaluate provider performance to ensure that Medicaid and Vendor standards are met. Such monitoring and evaluation system shall include a corrective action system. Vendor must include full documentation of the proposed monitoring system in the proposal.

g. The Vendor must notify Medicaid within one working day of any unexpected changes which would impair its provider network. This notification shall include:

1. Information about how the change will affect the delivery of covered services, and

2. The Vendor 's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

h. The Vendor is held accountable for any functions and responsibilities that it delegates to any subcontractor and must evaluate the subcontractors' ability to perform the activities delegated. The Vendor's subcontract(s) must:

1. Require subcontractors to fulfill the requirements of 42 C.F.R. 438.

2. Be in writing and specify the responsibilities delegated and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

3. Require the Vendor to monitor subcontractor's performance and conduct a formal review.

4. Require subcontractor to comply with accepted Medicaid standards of care.

5. Require subcontractor to comply with all applicable other terms and conditions contained in this RFP.

6. Contain subcontractor's reimbursement provisions.

7. Contain a provision specifying that subcontractor must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Vendor, insolvency of the Vendor, or breach of agreement) shall the subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for covered services, rendered during the term of subcontractor's agreement or sub-contract with the Vendor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients.

8. Contain a provision that states "payment for maternity-related services, not covered by the Maternity Care Program, does not make the recipient responsible for all of her maternity care".

9. Require that the contract term covers the same time period as the Vendor's contract with Medicaid.

10. Only be terminated for cause.

11. Require the Vendor to identify deficiencies and require the subcontractor to take corrective action.

F. REQUIREMENTS FOR SUBCONTRACTORS

The Vendor's proposal must present a plan (i.e., draft policies and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

The Vendor must have written policies for the selection and retention, credentialing and re-credentialing and non-discrimination of subcontractors. The Vendor may enter into subcontracts only where the subcontractor:

1. have current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements;

2. are enrolled as a Medicaid provider;

3. have current privileges at a hospital which participates in Medicaid, and be in good standing at that hospital; and

4. are not currently debarred or sanctioned from participation by any Federal department or agency.

The Vendor is required to notify Medicaid within two business days of time that a debarred provider is identified. The quarterly sanctions report that is distributed by Medicaid as well as the Debarred Provider List that is maintained at the federal level should be monitored on an ongoing basis to identify these individuals.

G. RECIPIENT CHOICE

The Vendor's proposal must present a plan (i.e., draft polices and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

Recipients must be allowed to choose a DHCP at the time of entry into the Maternity Care Program. If the recipient is enrolled in the Patient 1st Program, care continues through that program for non-maternity related services. A DHCP List must be available for use in the selection process. The Vendor must specify the approach in complying with choice requirements.

H. CHANGES IN THE SELECTION PROCESS

The Vendor's proposal must include an "acknowledgement and comply" statement regarding the following Maternity Care Program guidelines:

Recipients must be allowed to change healthcare professionals once without cause within the first 90 days of enrolling in the maternity program and at any time for just cause, which is defined as a valid complaint submitted to the Vendor in writing. Valid causes for disenrollment by the enrollee are set forth in 42 C.F.R. 438.56 (d) (2). Such request must be submitted by the recipient (or his/her representative) orally or in writing. The Vendor must notify all enrollees, at the time of enrollment, of the enrollee's rights to change providers or disenroll enrollment for cause. The recipient may request disenrollment without cause during the 90 days following the date of the recipient's initial enrollment with the Vendor or the date the Vendor sends the recipient notice of the enrollment, whichever is later. The Vendor must notify the enrollee of their right to request and obtain the information regarding disenrollment or changes in providers at least once per year. The Vendor must provide enrollee's of their disenrollment rights at a minimum annually. If there are any changes in the information the Vendor must notify the enrollee of the changes at least 30 days before the effective date of the change. If there are sanctions imposed upon the Vendor as specified in 42 C.F.R 438.702 (a) (3), the recipient may request disenrollment.

I. MEDICAL CARE SYSTEM

The Vendor's proposal must present a plan (i.e., draft polices and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

1. Covered Services

    a. The Vendor must have or arrange for a comprehensive system of maternity care that provides for pregnancy- related care, including high risk care, to all pregnant recipients that reside in the district, with the exception of those recipients that are exempted from the program. Refer to Maternity Care Program Operational Manual, Section V., Services, for further details of covered services. Below is a listing of the services that must be covered at a minimum:

        i. Antenatal Services, excluding inpatient care

        ii. Delivery Services, excluding inpatient care

        iii. Postpartum care services, excluding hospital inpatient care but including home visits when indicated

        iv. Care Coordination Services

    b. The Vendor must describe protocols for service delivery, including the process for managing high-risk pregnancies. Covered services must be medically necessary and encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy. The services to be provided through the Vendor's network and which will be

reimbursed as part of the global fee are described in the Maternity Care Program Operational Manual, Section V., Services.

c. The Vendor must describe how it will be responsible for pregnancy-related services as defined in this RFP from the time the pregnancy is diagnosed until the end of the month in which the 60th postpartum day falls. Maternity Care services are those that are pregnancy-related, medically necessary, and encompass maternity-related services as well as services to treat conditions that might otherwise complicate or exacerbate the pregnancy.

d. The Vendor is responsible for Specific CPT (current procedural terminology) codes which are included in the global rate. The codes are specified in the Maternity Care Program Operational Manual, Attachment Three, Global Associated Codes List. Specific CPT codes not included in the global rate are specified in the Maternity Care Program Operational Manual, Section V., Services.

2. Excluded Services

The Vendor's proposal must acknowledge all excluded services.

The following services as defined in the Maternity Care Program Operational Manual, Section V., Services, are excluded from the Maternity Care Program global payment methodology and are reimbursed fee-for-service:

a. Inpatient Care

b. Prescription Drugs

c. Injections

d. Family Planning visits

e. Lab services other than Hemoglobin, Hematocrit and Urinalysis

f. Radiology services with the exception of maternity ultrasounds. Maternity ultrasounds are unlimited in number and are a component of the global fee payment. A Vendor may develop an evidence-based prior authorization process to manage the number of ultrasounds performed.

g. Dental services

h. Circumcision

i. Physician charges for routine newborn care, standby and infant resuscitation

j. Non-pregnancy related care

k. Emergency Room Care (facility and physician)

l. Medicaid emergency and non-emergency transportation

m. Drop out fees

n. Face-to-Face Tobacco Cessation Counseling

o. Specialist referrals

p. Miscarriages <21 weeks

q. Program Exemptions

J. SERVICE DELIVERY

The Vendor's proposal must present a plan (i.e., draft polices and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

The Vendor shall have a delivery system that meets Medicaid requirements as defined in this proposal and any attachment and references hereto, as amended. All services defined in this proposal must be available, accessible and there must be an accessible and adequate number of facilities, locations and personnel for the provision of covered services 24 hours a day, seven days a week. Medicaid recipients must be offered the same access to provider office appointments and services that are available to all other maternity recipients of the Delivering Health Care Professional.

K. HIGH RISK PROTOCOL

The Vendor's proposal must present a plan (i.e., draft polices and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

A high risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth.

The Vendor must clearly describe in the proposal the way it will manage high-risk pregnancies, including a process for identifying high-risk cases, a method to denote high-risk status and the reason for high risk-status, a network for care, policy and procedures for monitoring referrals and services to be provided to high risk maternity recipients.

1. Referrals for high-risk care are the responsibility of the Vendor. **High risk care is not carved out of the Maternity District Plan.** Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a DHCP qualified to provide high-risk

care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

2. The following guidelines apply to teaching physicians and any Board Certified Perinatalogist approved to provide maternity services under a fee-for–service payment methodology outside of the Maternity District plan.

a. **Care Provided by a Teaching Physician**
The reimbursement for the provision of services provided by a teaching physician as defined in State Plan AL-11-022, 4.19-B which states *" Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds,"* is excluded from the global "and may be reimbursed fee-for-service.

b**. Care provided by a Board Certified Perinatalogist**
The reimbursement for the provision of high-risk care provided by a Board Certified Perinatalogist is excluded from the global and may be reimbursed fee-for-service. All routine maternity services are subject to the Maternity District's Plan. The Perinatalogist must subcontract with a Vendor for routine maternity services. Reimbursement for the provision of routine maternity services will be through the global payment methodology according to Vendor-subcontractor agreement.

c**. Routine Maternity Services Provided to Enrolled Recipients before or after Transferring to a Medicaid Enrolled Teaching Physician or Medicaid Enrolled Board Certified Perinatalogist**
Routine maternity services provided by a Vendor to an enrolled recipient before or after transferring to a Medicaid enrolled teaching physician for high risk care or routine care or a Medicaid enrolled Board Certified Perinatalogist for high risk care will be reimbursed fee-for-service and will not be reimbursed through the global payment methodology. Reference the Maternity Care Program Operational Manual, Section VIII., Payment of Services, for additional information.

L. CARE COORDINATION PROGRAM

The Vendor's proposal must present a plan (i.e., draft polices and procedures, or documents deemed necessary) to describe how it will meet each of the following requirements listed below.

An integral part of the medical care delivered through the Maternity Care Program is care coordination. Care coordination is a professional skill and should be supported from within the Vendor's system. Care coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure that the most comprehensive program meets the recipient's needs for care. Care coordination is to be utilized as a resource by which the system can be brought together for the betterment of the recipient.

1. The proposal must clearly operate a Care Coordination Program, to include, but not limited to, how the administrative component, medical component and other elements of the program are supported by the efforts of the Care Coordinators.

2. The Care Coordinator duties are as varied as the recipients served. Care Coordinators serve a vital role in ensuring that the medical care women receive is augmented with the appropriate psychosocial support. Care Coordinator responsibilities include, but are not limited to the following:

    a. Performing the initial encounter requirements;

    b. Performing encounter requirements;

    c. Performing the psychosocial risk assessment;

    d. Assessing the medical and social needs;

    e. Developing service plans;

    f. Providing information and education; and

    g. Tracking recipients throughout their pregnancy and postpartum period.

3. The Vendor must develop, implement and maintain polices, procedures and protocols related the daily operations of the Care Coordination Program.

4. The Entity must ensure that staff who is completing care coordination functions are operating within their professional scope of practice are appropriate for responding to recipients' needs and follow the States licensure/credentialing requirement as defined in the Maternity Care Operational Manual, Section VI., Care Coordination.

5. The proposal must include a stratification of care coordination and must

include visit flexibility to meet the needs of the recipient.

6. Minimums are established, but, beyond the minimum, the total number of visits should be dictated by the needs of the recipients. The Care Coordinator will be required to assess the recipient face to face at a minimum of two visits. The Care Coordinator will have flexibility to determine how to best improve outcomes.

7. If the medical or psychosocial status of the recipient changes, the Care Coordinator is responsible for adjusting the service plan and proceeding accordingly.

8. It is up to the DHCP and Care Coordinator to decide and develop a service plan that meets the recipient's needs.

M. REQUIREMENTS FOR CARE COORDINATORS

The Vendor's proposal must present a plan (i.e., draft polices or documents deemed necessary) to describe how it will meet the following requirement listed below. The Proposal must contain resumes all Care Coordinators.

1. Care Coordinators must have the following creditors:

   a. Social workers licensed and/or license-eligible for Alabama practice with a BSW or an MSW from a school accredited by the Council on Social Work Education. License-eligible social worker(s) must obtain license within12 months of date of employment to function as a Care Coordinator.

   b. Registered Nurses, licensed by the Alabama Board of Nursing, with a minimum of one year experience in care coordination, accessing resources, and coordinating care with low-income populations; or, if no care coordination experience, completion of a Care Coordinator training course provided by the Vendor and supervision by an experienced Care Coordinator for at least six months. Documentation must support the Care Coordinator's training has been completed and supervision for the specified period was provided. Compliance with this requirement will be reviewed during the Administrative Audit.

   c. Licensed Practical Nurse(s), licensed by the Alabama Board of Nurses, with at least two years of clinical experience and one year experience in care coordination, accessing resources and coordinating care with low-income populations.

2. The Vendor has flexibility in determining how to perform the Application Assister function. Care Coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Vendor. The Vendor may choose to use a Care Coordinator for this function, while others may choose to have other staff provide this function. Application Assister training is provided free of charge by the Alabama Medicaid Agency staff (Attachment Six of the Operational

Manual). The Vendor shall have an individual (s) designated as a trainer for the Train-the Trainer program. The designee must attend the Train-the-Trainer class and provide certification training to Application Assisters as deemed necessary in order to maintain compliance with certification and re-certification requirements. The certification period for Application Assisters and Train-the-Trainer designee is every two years.

3. Care Coordination is a professional skill and must be supported from within the Vendor system. Skills and functions employed by the Care Coordinator include, but are not limited to:

    a. Performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making all appropriate referrals (including Plan First and CoIIN referrals), and tracking recipients throughout their pregnancy and postpartum period.

    b. Community orientations, including the ability to locate, augment, and develop resources including information on services offered by other agencies.

    c. The Vendor must advise all subcontractors of Care Coordinators services and must require that the subcontractors refer all Medicaid recipients to enroll in the program with the Vendor within ten days of the first visit.

    d. The Care Coordinator shall provide the recipient with a business card that provides location and telephone number of the Care Coordinator should any questions arise.

    e. Care Coordinators must be located in an area which provides adequate recipient access and maintains recipient confidentiality. Private offices are preferred.

    f. Telephones must be available for use in recipient contacts.

    g. The Vendor must have a training plan for initial and on-going care coordination. These plans must at a minimum support the requirements of this document and include training specific to the maternity program and/or related topics on an on-going basis. Educational materials must include obtaining TPL information, the importance of keeping appointments with both the Care Coordinator and the DHCP, exemption candidates, current proper sleeping positions for the infant, domestic abuse, breast feeding, smoking & alcohol or other substance cessation, nutrition, and bonding for mother and infant. The effectiveness of the training plans will be monitored per quality outcome measures.

    h. The Care Coordinators or other Vendor's staff will enroll the recipient in the Maternity Care Program and start the Medicaid application process.

    i. The Vendor must have a system for verification of current license for each Care Coordinator. Verification of current licensure will be checked during the Administrative Audit.

N. HOME VISITS

Home visits are optional. Reference the Maternity Care Program Operational Manual, Section VII, Home Visits. The Vendor's proposal must address this optional service.

O. PAYMENT FOR SERVICES RENDERED

The Vendor's proposal must include an "acknowledgement and comply" statement regarding the following Maternity Care Program guidelines:

1. global/delivery only reimbursement methodology.

    a. The Vendor will receive a payment fee upon completion of the services provided. Global/delivery-only fees paid by Medicaid to the Vendor represent payment in full. These fees encompass all components of care as defined in Section II., Scope of Work, C., Medical Care System.

    b. Recipient may not be billed for any services covered under this proposal.

    c. For recipients who receive total care through the Vendor network, a global fee should be billed.

    d. For recipients who receive no prenatal care through the Vendor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period including all the required encounters by the Care Coordinator. The reimbursement amount for a delivery only is 80% of the global fee.

2. Subcontractor Reimbursement System

    a. The Vendor shall implement an automated reimbursement system for payments to subcontractors, out-of-plan providers and districts.

    b. The Vendor must ensure payments to subcontractors within 20 calendar days of the date of Medicaid payment (date funds deposited).

    c. The Vendor must ensure that in all cases, except where third party insurance billing is required by the DHCP, payments to subcontractors must be within 60 calendar days of the date of delivery.

    d. The Vendor must specify the payment methodology, i.e. capitation, fee for service, or partial capitation in provider subcontracts. The

reimbursement system must comply with Health Insurance Portability and Accountability Act.

e. The Vendor must ensure out-of-plan providers be paid within 90 calendar days of submission of a clean claim to the, unless the payment is under appeal.

3. DHCP Payment

a. DHCP, except for those associated with a teaching facility as defined in State Plan AL-11-022, 4.19-B, must be paid at a rate no less than the Medicaid fee-for-service urban rate for delivery only. The urban fee-for-service rate is $1,000 for delivery only. Nurse midwives are paid at 80% of that rate.

4. Third Party Liability

a. The Vendor is responsible for collecting all third party insurance information prior to submitting a request for payment to Medicaid. Recipients with third party coverage are required to follow program guidelines.

5. High Risk Transfers / Reimbursement Methodology

Routine maternity services provided to a recipient by a DHCP and/or Vendor before and after the transfer of a recipient to a teaching physician as define in State Plan AL-11-022,4.19-B or to a Medicaid enrolled Board Certified Perinatalogist will be reimbursed fee-for-service.

a. **Services Provided by a Vendor Before a High Risk Transfer**
The Vendor may receive an Administrative Collaborative Fee for enrolled recipients who are transferred to high risk care as described above. The Vendor may also receive an Administrative Collaborative Fee for enrolled recipients who receive routine maternity services from a teaching physician. The Administrative Collaborative Fee is paid for services provided by the Vendor which include, but is not limited to:

i. administration services;

ii. processing administrative review claims for subcontractors;

iii. RMEDE data collection, data entry, and data reporting from the time of enrollment by the Vendor o the end of the postpartum period for high risk recipients and recipients under routine care by a teaching physician as defined in State Plan AL-11-022, 4.19-B; and

iv. care coordination encounters.

b. The Administrative Collaborative Fee can be billed to the Alabama Medicaid Agency electronically and is not subject to the Administrative Review Process.

i. The procedure code for the Administrative Collaborative Fee is 99199 with a UA modifier and a Diagnosis Code of V239 indicating high risk transfer or routine maternity care by a teaching physician.

ii. The Administrative Collaborative fee is $365.00.

iii. The Vendor and/or DHCP/Subcontractors cannot bill a delivery code or a full global code for high risk transfers or routine care provided by a teaching physician.

NOTE THE EXCEPTION TO THIS REQUIREMENT
When maternity services are subcontracted under the umbrella of a Federally Qualified Health Center (FQHC) and a teaching physician (as defined in State Plan AL-11-022 4.19-B, the Vendor may bill an applicable global CPT code. The reimbursement of the FQHC for provision of maternity services will be the responsibility of the Vendor. The teaching physician will be reimbursed for provision of maternity services under the fee-for-service payment methodology. In this instance, the Administrative Collaborative fee cannot be billed by the Vendor.

c. **Services Provided by a DHCP/Subcontractor for a High Risk Transfer**

Claims for the provision of services by a DHCP/Subcontractor for a high risk transfer will be submitted to the Medicaid by the Vendor. These claims will be considered for payment through the Administrative Review Process. Types of Claims that may be submitted for consideration of payment include, but are not limited to:

i. Antepartum Care Claims

ii. Postpartum Care Claims

iii. Associated Services Claims

iv. Ultrasounds Claims

v. Claims for Referrals to specialty doctors

vi. Lab Claims

Reference the Maternity Care Program Operational Manual, Section V., Services, and the Provider Manual for further details regarding reimbursement methodology and Section VIII, D.4., Payment of Services for additional information about the Administrative Review Process.

P. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

The Vendor's proposal must present a plan (i.e., draft polices or documents deemed necessary) to describe how it will meet the following requirement listed below.

Quality Assurance and Performance improvement initiative of the Maternity Care Program. Quality Assurance and Performance Improvement (QAPI) is an integral part of the Maternity Care Program. Through QAPI, the adequacy and effectiveness, both in clinical and nonclinical areas of the program can be addressed. This section outlines the requirements of the program and the responsibilities of the Vendor and Medicaid. Within Medicaid, the Maternity Care Program Associate Director has primary responsibility for QAPI activities. Each facet of the QAPI process has its own unique roles and responsibilities.

Details on the requirements of the QAPI process are included in the Maternity Care Program Operational Manual, Sections IX., Quality Assurance and Performance Improvement and X., Records and Reports. Components include:

1. DHCP Report Cards

2. Vendor Report Cards (Refer to Maternity Care Program Operational Manual Section IX., Quality Assurance and Performance Improvement)

3. Grievance Procedures

4. Medicaid Agency Web Based Service Database

5. Performance Improvement Projects

6. Recipient Surveys

Q. MEDICAID OVERSIGHT

The Vendor's proposal must include an "acknowledgement and comply" statement regarding the following Maternity Care Program guidelines:

1. The Vendor's performance is monitored through a combination of performance measures, DHCP report cards, medical record reviews, Service Database reviews and administrative reviews. The purpose of oversight activities is to ensure that contract

requirements are being met, standards of care are being implemented and enforced and that the Vendor is meeting the expectations of the DHCP.

Details of the requirements of Oversight process are included in the Maternity Care Program Operational Manual Section IX., Quality Assurance and Performance Improvements.

a. Administrative Reviews

i. **Purpose** - To measure performance, the Vendor will be visited at least annually on-site to ensure compliance with program requirements.

ii. **Elements** - Detailed in **Figure 2**

Figure 2. Administrative Reviews Elements

Subcontractors not enrolled as Medicaid providers
Valid subcontracts (credentialing and licensure)
DHCP have hospital privileges
Claim payment within timeframes
Staff knowledge of billing/reimbursement policies
Training (Subcontractor and Care Coordinator) as required
Application Assister requirements
DHCP choice requirements

iii. **Standards** - If after the administrative review, the Vendor is found to not be meeting the requirements, the following damages for cost associated with breach of contract as indicated in **Figure 3** will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of damages for cost associated with breach of contract as a final act.

Figure 3. Administrative Measures and Damages for Cost Associated with Breach of Contract.

Measure	Damages for Cost Associated with Breach of Contract
Subcontractor not enrolled with Medicaid	1st occurrence: Corrective Action 2nd occurrence: $500 per provider not enrolled
Valid subcontracts	1st occurrence: Corrective Action 2nd occurrence: $500 per subcontract not meeting requirements
DHCP have hospital privileges	1st occurrence: Corrective Action 2nd occurrence: $500 per DHCP not having hospital privileges
Claim payment within timeframes	95% of audit sample of claims paid within timeframes, $100 per incident for payments not meeting timeframes

Staff knowledge of billing/reimbursement policies	1st occurrence: Corrective Action 2nd occurrence: Staff re-training, of $100 per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	$500 per training session not completed
Application Assister services	$500 per week that there is no certified Application Assister in all counties
DHCP choice requirements	1st occurrence: Corrective Action 2nd occurrence: $500 per choice requirements not met

iv. **Corrective Action -** If program requirements are not met, corrective action will be requested. The Vendor will implement a Corrective Action Plan and submit a signed report to the Medicaid Maternity Care program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Vendor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract described above in **Figure 3**.

b. Medical Record Reviews

i. **Purpose -** To ensure that each Vendor is providing quality maternity care to its recipients, determine the effectiveness of the Maternity Care Program and to ensure services are provided according to federal and state guidelines, medical record reviews in addition to the elements that are measured from the Web Database as described in the Maternity Care Program Operational Manual, Section XI., Medicaid Oversight will be conducted. Periodic reviews will be conducted to evaluate the effectiveness and adequacy of care coordination, and quality of care delivered by a Vendor and subcontractors.

Service Database Reviews will be completed simultaneously with medical record reviews to ensure that data collected is valid, timely, complete and comprehensive. Verifications will include, but will not be limited to verifying data quality, variances, validity, timeliness, completeness and accuracy with an expected error rate of no greater than 10%.

ii. **Sample Size/Process** - Reviews will be conducted on a semi- annual basis. The sample number of records will be chosen randomly from a DSS Query generated for a specific period of time prior to the review but in no case reflective of less than three months prior to the review month. A request for recipient records will be sent to the Vendor requesting that recipient's records be sent back to the Medicaid Managed Care Division for review. The Vendor will be responsible for obtaining all record information for review which

includes documentation from the DHCP, Hospital, etc. The subcontractor or the Vendor cannot charge for these records.

iii. **Findings** - After the review is completed and all data compiled, the Vendor will be provided a summary of the findings. Statewide statistical reports will be generated after all District reviews are completed, excluding Service Database reviews. Further review and/or a request for a corrective action plan may be necessary dependent on Medical Record and Service Database Review findings. Statewide statistical averages are computed by using weighted District averages to present a more accurate measurement due to the variation in the volume of deliveries per District.

iv. **Elements and Expectations**-Detailed in **Figure 4**.

Figure 4. Medical Record Reviews Elements and Expectations

Measure	What it is	Expectation
Care coordination encounters	The percentage of recipients for which a care coordination encounter was completed. If no encounter was completed in the hospital prior to discharge, were two attempts made to contact the recipient within 20 days of delivery so that the encounter could be accomplished?	90% of recipients receive an encounter.
Documentation of care coordination activities	All encounters are documented	100% of encounters are documented
Content of care coordination	Required encounters meet the guidelines specified in Section VI., Care Coordination , of the Maternity Care Program Operational Manual.	90% of encounters meet the required guidelines.
Service Database Verification-Content of data elements in the Service Database	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) entered into RMEDE is reflective of medical records and claims documentation	90% of the total selected audit sample Service Database elements should mirror medical record and claims documentation

Figure 5. Medical Record Reviews Standards and Damages for Cost Associated with Breach of Contract.

Measure	Damages for Cost Associated with Breach of Contract
Care coordination encounters	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient
No documentation of care coordination activity	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $700 per recipient
Content of care coordination	1st Occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient
Content of Service Database - RMEDE Verifications Source-Medical Record Reviews and Claims Data	1st Occurrence: Letter of Concern 2nd occurrence: Corrective Action Subsequent Occurrences if below established benchmark, $500 per occurrence

v. **Corrective Action** - If program requirements are not met, corrective action will be requested. The Vendor will implement a Corrective Action Plan and submit a signed report to the Medicaid Maternity Care program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Vendor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract described above in **Figure 5**.

c. Missing in Service Database (RMEDE) Reviews

i. **Purpose**-The purpose of the Missing in Service Database (RMEDE Review) is to ensure the Vendor has entered valid data into RMEDE in a timely fashion for recipients for whom a global fee was paid.

ii. **Sample Size/Process**- Reviews will be conducted quarterly, as outlined in Maternity Care Program Operational Manual, Section XI.,C. All deliveries for an identified quarter will be chosen randomly from a DSS Query using claims data generated for a specific period of time.

iii. **Findings**-After the review is completed and all data compiled, the District will be provided a summary of the findings. Further review and/or a request for a corrective action plan may be necessary dependent on the review findings

iv. **Elements and Expectations**- Detailed in **Figure 6**.

Figure 6. Service Database (RMEDE) Reviews Elements and Expectations

Measure	What it is	Expectation
Timeliness and valid Service Database Entries for Missing in RMEDE Reviews	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.	100 % of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.
Validity of Service Database Entries for Missing in RMEDE Reviews	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date with valid data compared to claims data	95% of data entry for each recipient who delivered in the district review period will be without error

v. **Corrective Action** - If program requirements are not met, corrective action will be requested. The Vendor will implement a Corrective Action Plan and submit written and **signed report** to the Medicaid Maternity Care program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Vendor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract described in **Figure 7**.

Figure 7. Service Database (RMEDE) Reviews Standards and Damages for Cost Associated with Breach of Contract

Measures	**Damages for Cost Associated with Breach of Contract**
Timeliness of Service Database Data Entries for Missing in RMEDE Reviews Source: Claims Data	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark, $500 per recipient
Validity of Service Database - Missing in RMEDE Reviews Source: Claims Data	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark, $100 per recipient

R. CORRECTIVE ACTION

1. The following standards will apply when the need for corrective action is identified:

    a. There must be a written, defined corrective action plan.

    b. The corrective action plan must be signed by the director.

    c. The plan must be acceptable to and approved by the Alabama Medicaid Agency.

2. The plan must include:

    a. Specification of the types of problems requiring remedial/corrective action

    b. Specification of the person(s) or body responsible for making the final determinations regarding quality problems

    c. Specific actions to be taken

    d. Provision of feedback to appropriate health professional, providers and staff

    e. The schedule and accountability for implementing corrective actions

    f. The approach to modifying the corrective action if improvements do not occur

    g. Procedures for terminating the affiliation with the physician or other health professional or provider

3. There must be an assessment of effectiveness of corrective actions.

    a. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

    b. The Vendor assures follow-up on identified issues to ensure that actions for improvement have been effective.

    c. Imposition of these damages for cost associated with breach of contract may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

S. REPORTS

The Vendor's proposal must contain a plan to meet the requirement:

1. Reporting Standards

The Vendor is responsible for timeliness, accuracy, and completeness of reports as defined below:

a. Timeliness – Reports and other required Service Database data must be received on or before scheduled due dates. Reporting requirements are based on calendar dates.

b. Accuracy – Reports and other required Service Database data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.

c. Completeness – All required information must be fully disclosed in a manner that is bother responsive and pertinent to report intent with no material omissions.

2. Reporting Requirements

a. The Vendor must submit Report as specified in the description of reports and as listed in **Figure 8**.

b. The Vendor is responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the term of the contract because of lag time in filing source documents by subcontractors.

c. Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. The Vendor must comply with all changes specified by Medicaid. The "to" contained in the subsequent chart indicates to where the report should be submitted. Maternity Care Program refers to the Associate Director, Maternity Care Program or a designee as directed by the Associate Director. Specific email addresses will be provided prior to contract implementation.

d. Reporting requirements as listed in **Figure 8** are the responsibility of the Vendor and are required on a routine basis. Details on specific reporting requirements may have been contained in other sections of the Maternity Care Program Operational Manual and referred to below. Failure to deliver reports in the manner and timeframe specified may result in damages for cost associated with breach of contract.

Figure 8. Reporting Requirements

Report Name	To	Media	Format	Timeframe	Due
Service Database	n/a	Web-based	In the format as designated in the Web based instructions	Data must be entered within 90 days of the delivery	Within 90 days of delivery

	Global Summary Report	MCP	Email	Excel as indicated in the format as specified in Attachment 19 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
	Organizational Structure	MCP	e-mail	Word	Annual and upon change	January 1st and/or within 5 days of occurrence
	Provider Network	MCP	e-mail	Excel as indicated in the format as specified in Attachment 20 of the Maternity Care Program Operational Manual	Annual and upon change	January 1st and/or within 5 days of occurrence (exception: due weekly for 30 days after contract award)
	Application Assisters	MCP	e-mail	Word as indicated in the format specified in Attachment 6 of the Maternity Care Program Operational Manual	Annual and upon change	Within 45 days of the end of the year and within 45 days of any change
	Quality Improvement Activity Summary	MCP	e-mail	Word as indicated in the format specified in Attachment 10 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
	Grievance and Appeal Log	MCP	e-mail	Word or excel format as indicated in the format specified in Attachment 18 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
	Quality Assurance Committee Meeting Minutes	MCP	e-mail	Word as indicated in the format specified in Attachment 16 of the Maternity Care Program Operational Manual	Quarterly	Within 45 days of the end of the quarter being reported
	Managed Care Organization (MCO)Experience Report	MCP	email	As indicated in the format as provided by the Alabama Medicaid Agency	Annually	Within 45 days of the end of each calendar year
	Quality	MCP	e-mail	Word as indicated	Quarterly	Within 45 days of

Improvement Tracking Log			in the format specified in Attachment 17 of the Maternity Care Program Operational Manual		the end of the quarter being reported
Sale, Exchange, Lease of Property	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods & Services	MCP	Paper	Word	Occurrence	Within 5 days of occurrence

3. Report Details

a. Service Database
The purpose of this report is to collect specifics on each delivery for which the Vendor receives payment. Information will be entered via a web-based database as described in Section IX.C., of the Maternity Care Program Operational Manual

b. Global Summary Report:
The purpose of this report is to collect specifics on amounts paid to subcontractors for services reimbursed through the global fee. The format and instructions are included in Attachment 19 of the Maternity Care Program Operational Manual.

c. Organizational Structure
This report indicates for Medicaid the individuals involved in the Vendor's organization. Significant changes must be reported to the Maternity Care Program Associate Director within 5 days of occurrence in a word format.

d. Provider Network
This report must be reflective of all subcontractors in the Vendor's network. Complete demographic information must be included, the service offered and the providers NPI number. The format and instructions are included in Attachment 20 of the Maternity Care Program Operational Manual.

e. Application Assister services- Vendor shall submit a list of counties and names of assigned Application Assisters and the name(s) of the Application Assisters' trainer to the Maternity Care Program Associate Director or designee annually and upon change. The format is included in Attachment 6 of the Maternity Care Program Operational Manual.

f. Quality Improvement Activity Summary

This report must summarize the District's Quality Improvement activity for the quarter. Details are contained in Section IX.G. The format and instructions are included in Attachments 10 and 10a of the Maternity Care Program Operational Manual.

g. Grievance Log
This report allows Medicaid to track issues as they arise as well as assure that each issue is resolved. Details are contained in Section IX.H. The format and instructions are included in Attachments 18 and 18a of the Maternity Care Program Operational Manual.

h. Quality Assurance Committee Meeting Minutes
This report allows the Quality Assurance Division to focus on quality improvement and quality concerns in individual districts and how improvements initiatives are implemented and the concerns are being resolved. Details are contained in Section IX.A. The format for reporting Quality Assurance Committee Meeting minutes is located in Attachment 16 of the Maternity Care Program Operational Manual.

i. MCO Experience Report
This report will be used during the development of delivery rates for the Alabama Medicaid Population. Each Vendor will be required to complete the report for each of its districts annually and as requested by Medicaid.

j. Tracking Log
A means by which the Vendor can identify and track problems and/or issues noted within their Districts. Identified problems or issues are taken to the QA Committee for discussion and recommendations.

k. Sale, Exchange, Lease or Property;
These reports are Centers for Medicare and Medicaid Services required for Managed Care Organizations and are required in a word format.

l. Loans or Extension of Credit
These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

m. Furnishing for Consideration of Goods and Services
These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

T. Implementation Activities

The Vendor's proposal must acknowledge and comply with each of the following requirements:

A. Readiness Review

Prior to the implementation date Medicaid may elect to conduct a readiness review with the Vendor to ensure that all program requirements are established. If this review is required it will be completed prior to the contract initiation. The purpose of the review will be to review administrative capability, provider subcontracts demonstrating the network, formal policies and procedures for recipient care, a system of care coordination and optional home visits, review of education and outreach material, participation in the subcontractor training session and review of the quality assurance process. A checklist for the review will be provided prior to the review in order to allow the Vendor time to prepare.

B. District Training Sessions

The Vendor will be required to hold a training session for subcontractors in its district. Advance notice of the date of the session shall be provided to Medicaid in writing. This session shall review all components of the program including, but not limited to, a review of billing procedures, procedure for protection of recipient choice, and quality assurance activities. Medicaid staff may attend but will not conduct these sessions.

C. Corrective Action Measures

In the event that a Vendor fails to meet the requirements of the Contract during the readiness review, the Vendor will be informed of its deficiencies in writing by Medicaid. The Vendor will be given a deadline by which time all identified deficiencies must be corrected to the satisfaction of Medicaid. The Vendor must respond within 48 hours of this notice of deficiencies with an acceptable corrective action plan.

In the event that a Vendor fails to correct the deficiencies noted by Medicaid within the time frame specified by Medicaid approved corrective action plan, Vendor will not be allowed to begin work. The geographic district covered by the deficient Vendor shall not participate in the Maternity Care Program and Medicaid eligible recipients shall receive their services under a fee-for-service system for a period of no greater than thirty calendar days. At the expiration of this thirty day period, Vendor's completion of the Medicaid corrective action plan will be evaluated.

If the Vendor has not corrected the deficiencies noted by Medicaid, the Vendor's contract with Medicaid will be terminated.

U. Duties Upon Expiration/Termination Transfer of Documents

At Medicaid's discretion but no later than three working days following the expiration or termination of the contract, Vendor at its own expense, shall box, label, and deliver to Medicaid or, at Medicaid's direction, the successor Vendor any information, data, manuals, records, claims or other documentation which shall permit Medicaid to continue contract performance or contract for further performance with another Vendor. Vendor shall organize and label this documentation by contract component.

Vendor shall at any time during the transition period and up to 90 calendar days after expiration of the contract answer all questions and provide all dialogue and training that Medicaid deems necessary to enable the successor Vendor to take over the provision of maternity care services. All such communications shall be with or through the Associate Director of the Maternity Program.

III. Pricing

The Vendor's proposal must include an "acknowledgement and comply" statement regarding the following Maternity Care Program guidelines:

A. The Vendor's proposal must contain a technical component and a pricing component. The technical component must present a complete and detailed description of the Vendor's qualification to perform and its approach to carry out the requirements of the RFP.

B. The pricing component is a firm and fixed price for **each year** of the contract, including any extensions. If the proposal does not contain a firm and fixed price for each delivery, it will not be considered to meet RFP submission requirements. As part of the firm and fixed price submission, Vendors must include details to support the development of the price including the amounts/percentages of the price to be spent on each component. Once the proposal price is received to the extent that the price is above or below the developed CY16 rate range, the price will be adjusted to appropriate levels within the actuarially sound rate ranges.

C. Rates ranges will be adjusted according to guidance provided by CMS in accordance with 42 CFR 438.6(c). Rate ranges will be developed using a combination of District specific encounter data, Managed Care Organization (MCO) Experience Financial Reports for the base data and other data as deemed necessary by the Certified Actuaries. Once the base data is established, prospective changes including trends, programmatic changes and non-medical load will be applied in order to develop actuarially sound rate ranges specific to each contract period. CMS defines actuarially sound rates as meeting the following criteria:

   1. Rates developed in accordance with generally accepted actuarial principles and practice;

   2. Rates appropriate for the populations to be covered and the services to be furnished under the contract; and

   3. Rates certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

D. Actuary reviews will be completed as often as necessary to keep all payments actuarially sound. Circumstances for actuary reviews include, but are not limited to,

significant changes to baseline data, significant program changes by the state, or significant changes in financial condition.

E. The successful Vendor in each district will be paid a global fee per delivery. The global fee for each delivery will be actuarially sound. The global fee will be payment in full for all services, duties, and administrative requirements as specified in the RFP. This will not be cost settled or modified and therefore should be considered as a firm and fixed price.

F. Vendors are to submit a single price per district for a global delivery. In paying individual claims, those figures will be reduced by 20% for persons who only receive services at the time of delivery and during the postpartum period.

G. Contracts for the provision of services under this RFP are risk-bearing and must be approved by CMS.

H. Contracts shall be amended to support actuarially sound rate ranges in accordance with 42 CFR 438.6(c) to include any contract extensions.

IV. General Medicaid Information

The Alabama Medicaid Agency is responsible for the administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. Through teamwork, the Agency strives to enhance and operate a cost efficient system of payment for health care services rendered to low income individuals through a partnership with health care providers and other health care insurers both public and private.

Medicaid's central office is located at 501 Dexter Avenue in Montgomery, Alabama. Central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services. For certain recipient categories, eligibility determination is made by Medicaid personnel located in eleven (11) district offices throughout the state and by approximately one hundred forty (140) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the Social Security Administration. In Nov 2014, more than 1,050,254 Alabama citizens were eligible for Medicaid benefits through a variety of programs.

Services covered by Medicaid include, but are not limited to, the following:

- Physician Services
- Inpatient and Outpatient Hospital Services
- Rural Health Clinic Services
- Laboratory and X-ray Services
- Nursing Home Services
- Early and Periodic Screening, Diagnosis and Treatment
- Dental for children ages zero (0) to twenty (20)
- Home Health Care Services and Durable Medical Equipment

- Family Planning Services
- Nurse-Midwife Services
- Federally Qualified Health Center Services
- Hospice Services
- Prescription Drugs
- Optometric Services
- Transportation Services
- Hearing Aids
- Intermediate Care Facilities for the Mentally Retarded and Mental Disease Services
- Prosthetic Devices
- Outpatient Surgical Services
- Renal Dialysis Services
- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services

Additional program information can be found at www.medicaid.alabama.gov.

V. General

This document outlines the qualifications which must be met in order for an entity to serve as Contractor. It is imperative that potential Contractors describe, **in detail,** how they intend to approach the Scope of Work specified in Section II of the RFP. The ability to perform these services must be carefully documented, even if the Contractor has been or is currently participating in a Medicaid Program. Proposals will be evaluated based on the written information that is presented in the response. This requirement underscores the importance and the necessity of providing in-depth information in the proposal with all supporting documentation necessary

The Vendor must demonstrate in the proposal a thorough working knowledge of program policy requirements as described, herein, including but not limited to the applicable Operational Manuals, State Plan for Medical Assistance, Administrative Code and Code of Federal Regulations (CFR) requirements.

Entities that are currently excluded under federal and/or state laws from participation in Medicare/Medicaid or any State's health care programs are prohibited from submitting proposal.

The proposal must contain an "acknowledgement and comply statement" regarding the following:

A. Medicaid is hereby seeking Vendors for the procurement of Maternity Care Services in each specific geographic areas, Districts 1 through 14, defined by this RFP. Services required are outlined throughout this RFP.

B. A separate proposal must be submitted for each district. Each proposal submission must be complete and stand on its own.

C. It is acceptable for a potential Vendor to create a common management or administrative infrastructure that would serve more than one district. Any such arrangement must be described and the functions must be satisfied for each proposal.

D. All proposals shall become the property of Medicaid.

E. The Vendor to whom a contract is awarded shall be responsible for the performance of all duties contained within this RFP. The Vendor will be responsible for implementation and coordination of a comprehensive maternity care delivery system (with the exception of the inpatient hospital component) that meets the needs of the Medicaid recipients within its district as described within this RFP. The mission of the program is to provide for the best possible birth outcome. This is accomplished through a coordinated system, augmented with care coordination and with an emphasis on quality.

F. The successful Vendor's delivery system will not include the inpatient hospital component. The inpatient hospital will be outside of the global Vendor reimbursement for maternity care.

G. All information contained in this RFP and any amendments reflect the best and most accurate information available to Medicaid at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for change of the payments to the Vendor or a basis for legal recovery of damages, actual, consequential or punitive, except to the extent that such inaccuracies are the result of intentional misrepresentation by Medicaid.

H. The submission of a proposal does not guarantee the award of a contract. Any contract resulting from the proposal is not effective until it has received all required governmental approvals and signatures. In addition, the selected Vendor shall not begin performing work under this contract until notified to do so by the departmental contracting agent. The projected implementation date of the contract is January 1, 2016.

I. The proposal must be received by the Medicaid as specified in the Schedule of Activities.

J. The proposal response must present a complete and detailed description of the Vendor's qualifications to perform such services, and its approach to carry out the requirements of this RFP. Complete program details are included in the 2016 Maternity Care Program Operational Manual. Vendors must review this Operational Manual in detail to gain a complete understanding of program requirements. In addition, Vendors are encouraged to review the Administrative Code (www.medicaid.alabama.gov); Code of Federal Regulations (www.access.gpo.gov); and the Medicaid Provider Billing Manual (www.medicaid.alabama.gov) prior to completing their proposal to ensure that all program requirements are understood and can be met. The proposal must explain how the requirements set forth will be met including examples where appropriate.

K. The proposal must contain documentation of the care delivery system that includes, but is not limited to:

1. A flowchart addressing both high and low risks recipient flow through the care system from entry into care to the conclusion of postpartum care;

2. A narrative explaining the recipient flow;

3. Protocols to be followed by providers for providing maternity care which prescribe services for prenatal visits, risk assessment, referral and follow up arrangements and postpartum services for both recipients at low and high risk;

4. List of all the proposed DHCP subcontractors with specialty;

5. Subcontractors are located within 50 miles of the location of recipients receiving care through the program;

6. Estimated DHCP/recipient ratio; and a

7. Specialty (high risk) hospital arrangements which are utilized by DHCP.

L. Submission of a response to this RFP, acceptance of the award, and signing of the contract and applicable attachments constitute evidence of Vendor's understanding of an agreement to the terms and conditions expressed in this proposal and contract.

M. This contract can only be offered in conjunction with an approved 1915(b) waiver. If the waiver is not granted or continued, then Medicaid does not have the legal authority to operate this program as explained in this RFP.

N. Medicaid may by written notice revise and amend the RFP prior to the due date for the proposal. If, in the opinion of Medicaid, revisions or amendments will require substantive changes in the RFP, the due date may be extended at the sole discretion of Medicaid.

VI. Corporate Background and References

Entities submitting proposals must:

a. Provide evidence that the Vendor possesses the qualifications required in this RFP.

b. Provide a description of the Vendor's organization, including:

1. Date established.

2. Ownership (public company, partnership, subsidiary, etc.). Include an organizational chart depicting the Vendor's organization in relation to any parent, subsidiary or related organization.

3. Number of employees and resources.

4. Names and resumes of Senior Managers and Partners in regards to this contract.

5. A list of all similar projects the Vendor has completed within the last three years.

6. A detailed breakdown of proposed staffing for this project, including names and education background of all employees that will be assigned to this project.

7. A list of all Medicaid agencies or other entities for which the Vendor currently performs similar work.

8. Evidence that the Vendor is financially stable and that it has the necessary infrastructure to complete this contract as described in the Vendor's Proposal. The Vendor must provide audited financial statements for the last three years, or similar evidence of financial stability for the last three years.

9. Details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Vendor or any of its officers, directors, employees, agents or subcontractors of which the Vendor has knowledge, or a statement that there are none. The Agency reserves the right to reject a proposal solely on the basis of this information.

c. Have all necessary business licenses, registrations and professional certifications at the time of the contracting to be able to do business in Alabama. Alabama law provides that a foreign corporation (a business corporation incorporated under a law other than the law of this state) may not transact business in the state of Alabama until it obtains a Certificate of Authority from the Secretary of State. To obtain forms for a Certificate of Authority, contact the Secretary of State, (334) 242-5324, www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the bid.

VII. Submission Requirements

A. Authority

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code and 45 CFR 74.40 through 74.48. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. No other evaluation criteria, other than as outlined in the RFP, will be used.

In accordance with 45 CFR 74.43, the State encourages free and open competition among Vendors. Whenever possible, the State will design specifications, proposal

requests, and conditions to accomplish this objective, consistent with the necessity to satisfy the State's need to procure technically sound, cost-effective services and supplies.

B. Single Point of Contact

From the date this RFP is issued until a Vendor is selected and the selection is announced by the Project Director, all communication must be directed to the Project Director in charge of this solicitation. **Vendors or their representatives must not communicate with any State staff or officials regarding this procurement with the exception of the Project Director.** Any unauthorized contact may disqualify the Vendor from further consideration. Contact information for the single point of contact is as follows:

Project Director:	**Sylisa Lee-Jackson**
	Managed Care Division
Address:	**Alabama Medicaid Agency**
	Lurleen B. Wallace Bldg.
	501 Dexter Avenue
	PO Box 5624
	Montgomery, Alabama 36103-5624
Telephone Number:	**334-353-4599**
Fax Number:	**334-353-9356**
E-Mail Address:	**sylisa.lee-jackson@medicaid.alabama.gov**

C. RFP Documentation

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc., will be posted to the Agency's website at www.medicaid.alabama.gov.

D. Questions Regarding the RFP

Vendors with questions requiring clarification or interpretation of any section within this RFP must submit questions and receive formal, written replies from the State. Each question must be submitted to the Project Director via email. Questions and answers will be posted on the website as available.

E. Acceptance of Standard Terms and Conditions

Vendor must submit a statement stating that the Vendor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed.

F. Adherence to Specifications and Requirements

Vendor must submit a statement stating that the Vendor has an understanding of and will comply with the specifications and requirements described in this RFP.

G. Order of Precedence

In the event of inconsistencies or contradictions between language contained in the RFP and a Vendor's response, the language contained in the RFP will prevail.

Should the State issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Vendor's proposal in the event of an inconsistency, ambiguity, or conflict.

H. Vendor's Signature

The proposal must be accompanied by the RFP Cover Sheet signed in ink by an individual authorized to legally bind the Vendor. The Vendor's signature on a proposal in response to this RFP guarantees that the offer has been established without collusion and without effort to preclude the State from obtaining the best possible supply or service. Proof of authority of the person signing the RFP response must be furnished upon request.

I. Offer in Effect for 90 Days

A proposal may not be modified, withdrawn or canceled by the Vendor for a 90-day period following the deadline for proposal submission as defined in the Schedule of Events, or receipt of best and final offer, if required, and Vendor so agrees in submitting the proposal.

J. State Not Responsible for Preparation Costs

The costs for developing and delivering responses to this RFP and any subsequent presentations of the proposal as requested by the State are entirely the responsibility of the Vendor. The State is not liable for any expense incurred by the Vendor in the preparation and presentation of their proposal or any other costs incurred by the Vendor prior to execution of a contract.

K. State's Rights Reserved

While the State has every intention to award a contract as a result of this RFP, issuance of the RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP;
- Reject any or all of the proposals submitted in response to this RFP;
- Change its decision with respect to the selection and to select another proposal;
- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);
- Negotiate with any Vendor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Vendor's proposal and to use any idea or all ideas presented in a proposal;
- Amend the RFP (amendments to the RFP will be made by written addendum issued by the State and will be posted on the RFP website);
- Not award any contract.

L. Price

Vendors must respond to this RFP by utilizing the RFP Cover Sheet to indicate the firm and fixed price for the implementation and updating/operation phase to complete the scope of work.

M. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to Maternity Care Program RFP Number **2015-MCMS-01** and the District the proposal is being submitted for. Proposals must be sent to the attention of the Project Director and received at the Agency as specified in the Schedule of Events. It is the responsibility of the Vendor to ensure receipt of the Proposal by the deadline specified in the Schedule of Events.

N. Copies Required

Vendors must submit one original Proposal with original signatures in ink, four additional hard copies in binder form, plus four electronic (Word format) copies of the Proposal on CD, jumpdrive or disc clearly labeled with the Vendor name the District for which the proposal is submitted for under sealed cover. One electronic copy MUST be a complete version of the Vendor's response and the second electronic copy MUST have any information asserted as confidential or proprietary removed. Vender must identify the original hard copy clearly on the outside of the proposal.

O. Late Proposals

Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be the Vendor's sole risk to assure delivery at the Agency by the designated deadline. Late proposals will not be opened and may be returned to the Vendor at the expense of the Vendor or destroyed if requested.

VIII. Evaluation and Selection Process

The Vendor's proposal must contain an "acknowledge and comply statement" regarding each of the following requirements listed below:

A. Initial Classification of Proposals as Responsive or Non-responsive

All proposals will initially be classified as either "responsive" or "non-responsive." Proposals may be found non-responsive at any time during the evaluation process or contract negotiation if any of the required information is not provided; or the proposal is not within the plans and specifications described and required in the RFP. If a proposal is found to be non-responsive, it will not be considered further.

Proposals failing to demonstrate that the Vendor meets the mandatory requirements listed in Appendix A will be deemed non-responsive and not considered further in the evaluation process (and thereby rejected).

B. Determination of Responsibility

The Project Director will determine whether a Vendor has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the vendor's specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Vendor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

C. Opportunity for Additional Information

The State reserves the right to contact any Vendor submitting a proposal for the purpose of clarifying issues in that Vendor's proposal. Vendors should clearly designate in their proposal a point-of-contact for questions or issues that arise in the State's review of a Vendor's proposal.

D. Evaluation Committee

An Evaluation Committee appointed by the Project Director will read the proposals, conduct corporate and personal reference checks, score the proposals, and make a written recommendation to the Commissioner of the Alabama Medicaid Agency. The State may change the size or composition of the committee during the review in response to exigent circumstances.

Proposals will be evaluated based on their responsiveness to the items contained in the RFP Proposal Response Section of this document. It is expected that the review committee will rate responses according to the following ways:

E. Scoring

The Evaluation Committee will score the proposals using the scoring system shown in the table below. The highest score that can be awarded to any proposal is 100 points.

Evaluation Factor	Highest Possible Score
Scope of Work	40%
Guidelines of the Program	35%
Staffing Qualification and Experience	25%
Total	**100**

F. Determination of Successful Proposal

The Vendor whose proposal is determined to be in the best interest of the State will be recommended as the successful Contractor. The Project Director will forward this Vendor's proposal through the supervisory chain to the Commissioner, with documentation to justify the Committee's recommendation.

When the final approval is received, the State will notify the selected Vendor. If the State rejects all proposals, it will notify all Vendors. The State will post the

award on the Agency website at www.medicaid.alabama.gov. The award will be posted under the applicable RFP number.

IX. General Terms and Conditions

A. General

This RFP and Contractor's response thereto shall be incorporated into a contract by the execution of a formal agreement. The contract and amendments, if any, are subject to approval by the Governor of the State of Alabama.

The contract shall include the following:

1. Executed contract,
2. RFP, attachments, and any amendments thereto,
3. Contractor's response to the RFP, and shall be construed in accordance with and in the order of the applicable provisions of:
    - Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations
    - The statutory and case law of the State of Alabama
    - The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended
    - The Medicaid Administrative Code
    - Medicaid's written response to prospective Vendor questions

B. Compliance with State and Federal Regulations

Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. Medicaid retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

C. Term of Contract

Medicaid will enter into one contract for each of the 14 geographical districts for 12 month period commencing January 1, 2016 through December 31, 2016.

At the end of the contract period, Medicaid may at its discretion, exercise the extension option and allow the period of performance to be extended for an additional contract year for up to a total of four contract extensions or at such time a Regional Care Organization assumes the management of maternity service in a district or region. Such option shall be exercised by written notice to the Vendor within 90 days prior to the termination date of the contract or any extension.

Contracts for the provision of services under this RFP are risk-bearing and must be approved by CMS. Contracts shall be amended to support actuarially sound rate ranges in accordance with 42 CFR 438.6(c).

Vendor acknowledges and understands that this contract is not effective until it has received all requisite state government approvals and Contractor shall not begin performing work under this contract until notified to do so by Medicaid. Contractor is entitled to no compensation for work performed prior to the effective date of this contract.

In October 2016, Medicaid will implement Medicaid managed care utilizing Regional Care Organizations (RCOs). Once implemented, the RCO's will bear the risk of contracting with the State to provide the health care for Medicaid recipients. Initially, recipients receiving nursing home, hospice and HCBS waiver services, foster children, Plan 1st recipients, and recipients with dual eligibility (Medicare and Medicaid) will be excluded from the RCOs. As a result, the RCO will be responsible for certain aspects of the coordination of benefits for its members.

D. Contract Amendments

No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto. The contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

The contract shall be deemed to include all applicable provisions of the State Plan and of all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affects the operation of the Alabama Medicaid Program or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change.

E. Confidentiality

Contractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §160.101 – 164.534. Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this contract.

Contractor shall ensure safeguards that restrict the use or disclosure of information concerning individuals to purposes directly connected with the administration of the Plan in accordance with 42 CFR Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the Plan administration include:

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), the successful Contractor shall sign and comply with the terms of a Business Associate agreement with the Agency (Appendix B).

F. Security and Release of Information

Contractor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. Contractor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

G. Federal Nondisclosure Requirements

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as five years, or both, together with the cost of prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

Additionally, it is incumbent upon the contractor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC 552a. Specifically, 5 USC 552a (i) (1), which is made applicable to contractors by 5 USC 552a (m) (1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

H. Contract a Public Record

Upon signing of this contract by all parties, the terms of the contract become available to the public pursuant to Alabama law. Contractor agrees to allow public access to all documents, papers, letters, or other materials subject to the current

Alabama law on disclosure. It is expressly understood that substantial evidence of Contractor's refusal to comply with this provision shall constitute a material breach of contract.

I. Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy of a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of Medicaid, constitute default by Contractor effective the date of such filing. Contractor shall inform Medicaid in writing of any such action(s) immediately upon occurrence by the most expeditious means possible. Medicaid may, at its option, declare default and notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor.

J. Termination for Default

Medicaid may, by written notice, terminate performance under the contract, in whole or in part, for failure of Contractor to perform any of the contract provisions. In the event Contractor defaults in the performance of any of Contractor's material duties and obligations, written notice shall be given to Contractor specifying default. Contractor shall have 10 calendar days, or such additional time as agreed to in writing by Medicaid, after the mailing of such notice to cure any default. In the event Contractor does not cure a default within 10 calendar days, or such additional time allowed by Medicaid, Medicaid may, at its option, notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor.

K. Termination for Unavailability of Funds

Performance by the State of Alabama of any of its obligations under the contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. If Medicaid, in its sole discretion, deems at any time during the term of the contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, Medicaid shall promptly notify Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to Medicaid, State or Federal Government.

L. Proration of Funds

In the event of proration of the funds from which payment under this contract is to be made, this contract will be subject to termination.

M. Termination for Convenience

Medicaid may terminate performance of work under the Contract in whole or in part whenever, for any reason, Medicaid, in its sole discretion determines that such termination is in the best interest of the State. In the event that Medicaid elects to terminate the contract pursuant to this provision, it shall so notify the Contractor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, Contractor will be entitled only to payment for all work satisfactorily completed

and for reasonable, documented costs incurred in good faith for work in progress. The Contractor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

N. Force Majeure

Contractor shall be excused from performance hereunder for any period Contractor is prevented from performing any services pursuant hereto in whole or in part as a result of an act of God, war, civil disturbance, epidemic, or court order; such nonperformance shall not be a ground for termination for default.

O. Nondiscriminatory Compliance

Contractor shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

P. Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 CFR Part 74 and paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

Q. Worker's Compensation

Contractor shall take out and maintain, during the life of this contract, Worker's Compensation Insurance for all of its employees under the contract or any subcontract thereof, if required by state law.

R. Employment of State Staff

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract any professional or technical personnel, who are or have been in the employment of Medicaid during the previous twelve (12) months, except retired employees or contractual consultants, without the written consent of Medicaid. Certain Medicaid employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1 et seq., code of Alabama 1975.

S. Immigration Compliance

Contractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Contractor shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Beason- Hammon Alabama Taxpayer and Citizen Protection Act (Ala, Act 2012- 491 and any amendments thereto) and certify its compliance by executing Attachment G. Contractor will document that the Contractor is enrolled in the E-Verify Program operated by the US Department of Homeland Security as required by Section 9 of Act 2012-491. During the performance of the contract,

the contractor shall participate in the E-Verify program and shall verify every employee that is required to be verified according to the applicable federal rules and regulations. Contractor further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of the services pursuant to this contract, that the Contractor will secure from such subcontractor(s) documentation that subcontractor is enrolled in the E-Verify program prior to performing any work on the project. The subcontractor shall verify every employee that is required to be verified according to the applicable federal rules and regulations. This subsection shall only apply to subcontractors performing work on a project subject to the provisions of this section and not to collateral persons or business entities hired by the subcontractor. Contractor shall maintain the subcontractor documentation that shall be available upon request by the Alabama Medicaid Agency.

Pursuant to Ala. Code §31-13-9(k), by signing this contract, the contracting parties affirm, for the duration of the agreement, that they will not violate federal immigration law or knowingly employ, hire for employment, or continue to employ an unauthorized alien within the state of Alabama. Furthermore, a contracting party found to be in violation of this provision shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom.

Failure to comply with these requirements may result in termination of the agreement or subcontract.

T. Share of Contract

No official or employee of the State of Alabama shall be admitted to any share of the contract or to any benefit that may arise there from.

U. Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties.

V. Warranties Against Broker's Fees

Contractor warrants that no person or selling agent has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission percentage, brokerage, or contingency fee excepting bona fide employees. For breach of this warranty, Medicaid shall have the right to terminate the contract without liability.

W. Novation

In the event of a change in the corporate or company ownership of Contractor, Medicaid shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity must agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and Medicaid execution of the novation agreement, a valid contract shall continue to exist between Medicaid and the original Contractor. When, to Medicaid's satisfaction, sufficient evidence has

been presented of the new owner's ability to perform under the terms of the contract, Medicaid may approve the new owner and a novation agreement shall be executed.

X. Employment Basis

It is expressly understood and agreed that Medicaid enters into this agreement with Contractor and any subcontractor as authorized under the provisions of this contract as an independent Contractor on a purchase of service basis and not on an employer-employee basis and not subject to State Merit System law.

Y. Disputes and Litigation

Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of Contractor and the RFP shall be controlled by the provisions of the RFP. Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Commissioner of Medicaid.

The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this contract shall be limited to the filing of a claim with the board of Adjustment for the State of Alabama. Pending a final decision of a dispute hereunder, the Contractor must proceed diligently with the performance of the contract in accordance with the disputed decision.

For any and all disputes arising under the terms of this contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through private mediators.

Any litigation brought by Medicaid or Contractor regarding any provision of the contract shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision shall not be deemed an attempt to confer any jurisdiction on these courts which they do not by law have, but is a stipulation and agreement as to forum and venue only.

Z. Records Retention and Storage

Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the three- year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution.

AA. Inspection of Records

Contractor agrees that representatives of the Comptroller General, HHS, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and Medicaid and their authorized representatives shall have the right during business hours to inspect and copy Contractor's books and records pertaining to contract performance and costs thereof. Contractor shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. Contractor may require that a receipt be given for any original record removed from Contractor's premises.

BB. Use of Federal Cost Principles

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Chapter 1, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

CC. Payment

Global/delivery-only fees paid by Medicaid to the Vendor represent payment in full. Recipients may not be billed for any services covered under this proposal.

DD. Notice to Parties

Any notice to Medicaid under the contract shall be sufficient when mailed to the Project Director. Any notice to Contractor shall be sufficient when mailed to Contractor at the address given on the return receipt from this RFP or on the contract after signing. Notice shall be given by certified mail, return receipt requested.

EE. Disclosure Statement

The successful Vendor shall be required to complete a financial disclosure statement with the executed contract.

FF. Debarment

Contractor hereby certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any Federal department or agency.

GG. Not to Constitute a Debt of the State

Under no circumstances shall any commitments by Medicaid constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this contract shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of this

Contract, be enacted, then that conflicting provision in the contract shall be deemed null and void. The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

HH. Qualification to do Business in Alabama

Should a foreign corporation (a business corporation incorporated under a law other than the law of this state) be selected to provide professional services in accordance with this RFP, it must be qualified to transact business in the State of Alabama and possess a Certificate of Authority issued by the Secretary of State at the time a professional services contract is executed. To obtain forms for a Certificate of Authority, contact the Secretary of State at (334) 242-5324 or www.sos.state.al.us. The Certificate of Authority or a letter/form showing application has been made for a Certificate of Authority must be submitted with the proposal.

II. Choice of Law

The construction, interpretation, and enforcement of this contract shall be governed by the substantive contract law of the State of Alabama without regard to its conflict of laws provisions. In the event any provision of this contract is unenforceable as a matter of law, the remaining provisions will remain in full force and effect.

JJ. Alabama interChange Interface Standards

Contractor hereby certifies that any exchange of MMIS data with the Agency's fiscal agent will be accomplished by following the Alabama interChange Interface Standards Document, which will be posted on the Medicaid Website, www.medicaid.alabama.gov.

X. Performance Guarantee

The Vendor's proposal must acknowledge and comply with each of the following Requirements:

In order to assure full performance of all obligations imposed on a Vendor contracting with the State of Alabama, the Vendor will be required to provide a performance guarantee in an amount equal to one percent of the expected annual Medicaid payment. The actual figure will be based on the firm and fixed price multiplied by the expected number of annual deliveries multiplied by one percent. The performance guarantee must be submitted by Vendor at least ten calendar days prior to the contract start date. The form of performance guarantee shall be one of the following:

a. Cashier's Check (personal or company checks are not acceptable)

b. Other type of bank certified check

c. Money order

d. An irrevocable letter of credit

e. Surety bond issued by a company authorized to do business within the State of Alabama

The Alabama Medicaid Agency's Director of Financial Administration shall be the custodian of the performance guarantee. The performance guarantee shall reference this RFP and it shall be made payable to the State of Alabama.

If Vendor fails to deliver the required performance guarantee, the proposal shall be rejected and the contract may be awarded to the provider of the next ranked proposal.

In the event of a breach of contract, Medicaid will notify Vendor in writing of the default and may assess reasonable charges against the Vendor's Performance guarantee.

Failure of the Vendor to perform satisfactorily, breach of contract, or termination of contract shall cause the performance guarantee to become due and payable to the state of Alabama to the extent necessary to cover the costs incurred by Medicaid as a result of the Vendor failure to perform its contractual obligations.

These cost include, but not limited to cost to correct any Medicaid errors caused by the Vendor's default and cost incurred by Medicaid for completion of contracted work including any cost associated with preparation , solicitation and award of a competitive proposals for these contract services and any federal, state or other penalties, sanctions, disallowance, or any other cost incurred by Medicaid as a result of the Vendors default and any sanctions and/or liquidated damages necessary as a result of the Vendor default.

In order to achieve the greatest economy for the State, Medicaid may choose the next responsive Vendor, re-release the RFP, or complete any other action consistent with state purchasing laws.

Performance Guarantees shall remain current and enforced for the duration of the contract as well as extension options. The performance guarantee will be released within 60 days of the end of the contract term.

XI. Damages for Cost Associated with Breach of Contract/Liquidated Damages

The Vendor's proposal must acknowledge and comply with the following requirements:

In the event that Vendor fails to meet the requirements of this RFP and contract requirements, Medicaid will recover damages for cost associated with breach of contract. Vendor agrees to pay Medicaid the sums set forth below unless waived by Medicaid**.**

A. Failure to deliver requisite reports/recipient records/services/deliverables as defined by the RFP by the date specified by Medicaid - $100 per day per report or review.

B. Failure to provide documentation as required by the RFP - $1,000 per instance.

C. Failure to comply with any other requirement of the RFP - $1,000 per instance.

D. Failure to perform tasks as specified in the RFP within the time specified by Medicaid, including but not limited to data entered into the Service Database - $100 per day.

E. Failure to submit an acceptable required corrective action plan - $1,000 per instance.

F. Failure to maintain adequate staffing levels necessary to perform the requirements of the RFP - $1,000 per instance.

G. Failure to meet technical requirements - $1,000 per instance.

H. Insufficient or absence of Care Coordination documentation to meet required benchmark - $500.00 per medical record.

I. Misrepresentation or falsification of information furnished to Centers for Medicare and Medicaid Services. Medicare/Medicaid Services, to the State, to an enrollee, potential enrollee or health care provider- $5,000 per instance.

J. Vendor shall be liable for any penalties or disallowance of Federal Financial Participation incurred by Medicaid due to Vendor's failure to comply with the terms of the contract. Total dollars may include State funds as well as federal funds.

K. Imposition of damages for cost associated with breach of contract and liquidated damages may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

L. Unauthorized use of information shall be subject to the imposition of damages for cost associated with breach of contract in the amount of ten thousand dollars ($10,000) per instance.

M. Failure to safeguard confidential information of providers, recipients or the Medicaid program shall be subject to the imposition of $10,000 per instance for damages for cost associated with breach of contract and any penalties incurred by Medicaid for said infractions.

N. Other damages for cost associated with breach of contract are noted in Section II.Q. Medicaid Oversight.

Vendor shall receive written notice from Medicaid upon a finding of failure to comply with contract requirements, which contains a description of the events that resulted in such a finding. Vendor shall be allowed to submit rebuttal information or testimony in opposition to such findings. Medicaid shall make a final decision regarding implementation of damages for cost associated with breach of contract.

XII. Contract Ending Transition and Implementation Plan Incumbent

The Vendor's proposal must acknowledge and comply with the following requirements:

At the end of the contract period to be covered by this RFP (January 1, 2016– December 31, 2016, unless extended), the following payments will be made for transitioning recipients. Transitioning recipients are women who entered care with a Vendor and have not delivered the infant when the new contract begins.

a. If the **same** Vendor is awarded the contract for the district payment for all services will be at the new global rate beginning with the new contract period. There will be no settlement for women who transition from one contract period to the next.

b. If a **new** Vendor is awarded the contract for a district:

1. The incumbent Vendor will be paid $100 for each recipient that did not deliver prior to the end of the contract period. It will be a lump sum payment to cover costs incurred. The incumbent Vendor will be responsible for payment to subcontractors for services rendered to the end of the contract period.

2. New Vendor will receive payment for deliveries from Medicaid as follows for women that have not delivered and were enrolled with the prior Vendor:

- 1st month --97% of global delivery fee paid for recipients delivering in the first month of the new contract.

- 2nd month--98% of global delivery fee paid for recipients delivering in the second month of the new contract period.

- 3rd month--99% of global delivery fee paid for recipients delivering in the third month of the new contract period.

- After the third month--100% of the global fee will be paid.

c. For recipients in their third trimester, a startup exemption may be granted if their physician is not participating with the new Vendor. Such exemptions must be received by the end of the contract period to a new Vendor.

d. Incumbent entities must submit a list of recipients transitioning out no later than thirty days prior to new contract start date to Medicaid's Maternity Care Program Associate Director.

XIII. Contract Ending Transition and Implementation Plan from Vendor to RCO

The Vendor's proposal must acknowledge and comply with the following requirements:

The Vendor will be responsible for services performed up to 11:59 pm CT on September 30, 2016. The Vendor will not receive a global payment for deliveries occurring after September 30, 2016. The Contractor may bill Medicaid fee-for-service for services performed by a DHCP up to 11:59 pm CT on September 30, 2016 for patients that have not delivered as of 11:59 pm CT on September 30, 2016. The Vendor may only bill codes covered in the Global Associated Codes List, and will bill no more than the Medicaid fee schedule. The Vendor will also receive a transition fee of $135.88 for each transitioning recipient.

At the end of the Vendor service period covered by this RFP (January 1, 2016 – September 30, 2016), the following payments will be made for transitioning patients. Transitioning patients are women who entered care with a Vendor and have not delivered as of 11:59 pm CT on September 30, 2016. New patients will not be enrolled with Vendor after September 30, 2016. The Vendor will coordinate service and corporate with the RCO in the assigned region to ensure a smooth transition and continuity of recipient care.

The Vendor will have until October 1, 2016 through December 31, 2016 to submit outstanding claims and resolve all billing issues.

Appendix A: Proposal Compliance Checklist

NOTICE TO VENDOR:

It is highly encouraged that the following checklist be used to verify completeness of Proposal content. It is not required to submit this checklist with your proposal.

Vendor Name

Project Director Review Date

*Proposals for which **ALL** applicable items are marked by the Project Director are determined to be compliant for responsive proposals.*

☒ IF CORRECT	BASIC PROPOSAL REQUIREMENTS
☐	1. Vendor's original proposal received on time at correct location.
☐	2. Vendor submitted the specified copies of proposal and in electronic format.
☐	3. The Proposal includes a completed and signed RFP Cover Sheet.
☐	4. The Proposal is a complete and independent document, with no references to external documents or resources.
☐	5. Vendor submitted signed acknowledgement of any and all addenda to RFP.
☐	6. The Proposal includes written confirmation that the Vendor understands and shall comply with all of the provisions of the RFP.
☐	7. The Proposal includes required client references (with all identifying information in specified format and order).
☐	8. The Proposal includes a corporate background.
☐	9. The response includes (if applicable) a Certificate of Authority or letter/form showing application has been made with the Secretary of State for a Certificate of Authority.
☐	10. The Proposal includes Letters of Intent
	RFP References for Acknowledgement and Comply Statements
☐	**II.D Maternity Care Program Guidelines**
☐	**II.H Changes in the Selection Process**

☐	**II.I.2 Medical Care System**
☐	**II.O Payment for Services Rendered**
☐	**II.Q Medicaid Oversight**
☐	**II.T Implementation Activities**
☐	**III. Pricing**
☐	**V. General**
☐	**VIII. Evaluation and Selection Process**
☐	**X. Performance Guarantee**
☐	**XI. Damages for Cost Associated with Breach of Contract/Liquidated Damages**
☐	**XII. Contract Ending Transition and Implementation Plan Incumbent**
☐	**XIII. Contract Ending Transition and Implementation Plan from Vendor to RCO**

Appendix B: Contract and Attachments

The following are the documents that must be signed AFTER contract award and prior to the meeting of the Legislative Contract Oversight Committee Meeting. The current copy of these documents can be found on the Q drive in the LEGAL/Contract Forms folder.

Sample Contract	
Attachment A:	Business Associate Addendum
Attachment B:	Contract Review Report for Submission to Oversight Committee
Attachment C:	Immigration Status
Attachment D:	Disclosure Statement
Attachment E:	Letter Regarding Reporting to Ethics Commission
Attachment F:	Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
Attachment G:	Beason-Hammon Certificate of Compliance

CONTRACT
BETWEEN
THE ALABAMA MEDICAID AGENCY
AND

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and _____, Contractor, agree as follows:

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Request for Proposal (RFP Number _____, dated _____, strictly in accordance with the requirements thereof and Contractor's response thereto.

Contractor shall be compensated for performance under this contract in accordance with the provisions of the RFP and the price provided on the RFP Cover Sheet response, in an amount not to exceed _____.

Contractor and the Alabama Medicaid Agency agree that the initial term of the contract is ____to _____.

This contract specifically incorporates by reference the RFP, any attachments and amendments thereto, and Contractor's response.

CONTRACTOR

_____
Contractor's name here

_____
Date signed

_____
Printed Name

Tax ID:_____

APPROVED:

_____
Governor, State of Alabama

ALABAMA MEDICAID AGENCY
This contract has been reviewed for and is approved as to content.

_____
Stephanie McGee Azar
Acting Commissioner

_____
Date signed

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

_____
General Counsel

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

1.1. Covered Entity and Business Associate are parties to a contract entitled _____ _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

1.2. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Rules (as defined below).

1.3. The Parties enter into this Business Associate Addendum with the intention of complying with the HIPAA Rules allowing a covered entity to disclose protected health information to a business associate, and allowing a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

2.1 General Definitions

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Protected Health Information, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

2.2 Specific Definitions

2.2.1 Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 C.F.R. § 160.103

2.2.2 Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 C.F.R. § 160.103.

2.2.3 HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate agrees to the following:

3.1 Use or disclose PHI only as permitted or required by this Agreement or as Required by Law.

3.2 Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. Further, Business Associate will implement administrative, physical and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by Subpart C of 45 C.F.R. Part 164.

3.3 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

3.4 Report to Covered Entity within five (5) business days any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

3.5 Ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and § 164.308(b)(2), if applicable.

3.6 Provide Covered Entity with access to PHI within thirty (30) business days of a written request from Covered Entity, in order to allow Covered Entity to meet its requirements under 45 C.F.R. § 164.524, access to PHI maintained by Business Associate in a Designated Record Set.

3.7 Make amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 C.F.R. § 164.526 at the written request of Covered Entity, within thirty (30) calendar days after receiving the request.

3.8 Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary within five (5) business days after receipt of written notice or as designated by the Secretary for purposes of determining compliance with the HIPAA Rules.

3.9 Maintain and make available the information required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI as necessary to satisfy the Covered Entity's obligations under 45 C.F.R. § 164.528.

3.10 Provide to the Covered Entity, within thirty (30) days of receipt of a written request from Covered Entity, the information required for Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

3.11 Maintain a comprehensive security program appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities as defined in the Security Rule.

3.12 Notify the Covered Entity within five (5) business days following the discovery of a breach of unsecured PHI on the part of the Contractor or any of its sub-contractors, and

3.12.1 Provide the Covered Entity the following information:

3.12.1(a) The number of recipient records involved in the breach.

3.12.1(b) A description of what happened, including the date of the breach and the date of the discovery of the breach if known.

3.12.1(c) A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).

3.12.1(d) Any steps the individuals should take to protect themselves from potential harm resulting from the breach.

3.12.1(e) A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.

3.12.1(f) Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.

3.12.1(g) A proposed media release developed by the Business Associate.

3.12.2 Work with Covered Entity to ensure the necessary notices are provided to the recipient, prominent media outlet, or to report the breach to the Secretary of Health and Human Services (HHS) as required by 45 C.F.R. Part 164, Subpart D.;

3.12.3 Pay the costs of the notification for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate;

3.12.4 Pay all fines or penalties imposed by HHS under 45 C.F.R. Part 160, "HIPAA Administrative Simplification: Enforcement Rule" for breaches that occur as a result of any act or failure to act on the part of any employee, officer, or agent of the Business Associate.

3.12.5 Co-ordinate with the Covered Entity in determining additional specific actions that will be required of the Business Associate for mitigation of the breach.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may

4.1. Use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Subpart E of 45 C.F.R. Part 164 if done by Covered Entity;

4.2. Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.3. Disclose PHI for the proper management and administration of the Business Associate, provided that:

4.3.1 Disclosures are Required By Law; or

4.3.2 Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

4.4 Use PHI to provide data aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

5. REPORTING IMPROPER USE OR DISCLOSURE

The Business Associate shall report to the Covered Entity within five (5) business days from the date the Business Associate becomes aware of:

5.1 Any use or disclosure of PHI not provided for by this agreement

5.2 Any Security Incident and/or breach of unsecured PHI

6. OBLIGATIONS OF COVERED ENTITY

The Covered Entity agrees to the following:

6.1 Notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

6.2 Notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

6.3 Notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

6.4 Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

6.5 Provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services to which this agreement pertains.

7. TERM AND TERMINATION

7.1 Term. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

7.2 Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

7.2.1 Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

7.2.2 Immediately terminate this Agreement; or

7.2.3 If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

7.3 Effect of Termination.

7.3.1 Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2 In the event that Business Associate determines that the PHI is needed for its own management and administration or to carry out legal responsibilities, and returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall:

7.3.2(a) Retain only that PHI which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

7.3.2(b) Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the business associate still maintains in any form;

7.3.2(c) Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the PHI;

7.3.2(d) Not use or disclose the PHI retained by business associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 4, "Permitted Uses and Disclosures" which applied prior to termination; and

7.3.2(e) Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

7.4 Survival

The obligations of business associate under this Section shall survive the termination of this Agreement.

8. GENERAL TERMS AND CONDITIONS

8.1 This Agreement amends and is part of the Contract.

8.2 Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

8.3 In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the HIPAA Rules shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.

8.4 A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

8.5 The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the HIPAA Rules.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: Clay Gaddis

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Contract Review Permanent Legislative Oversight Committee
Alabama State House
Montgomery, Alabama 36130

CONTRACT REVIEW REPORT

(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor:

Contractor's Physical Street Address (No. P.O. Box) City
State

* Is Contractor organized as an Alabama Entity in Alabama? YES_____NO_____
* If not, has it qualified with the Alabama Secretary of State to do business in Alabama? YES_____
NO_____

Is Act 2001-955 Disclosure Form Included with this Contract? YES ___X___ NO _____
Does Contractor have current member of Legislature or family member of Legislator employed?
YES_____NO_____
Was a lobbyist/consultant used to secure this contract OR affiliated with this contractor? YES_____
NO_____
If Yes, Give Name:

Contract Number:

Contract/Amendment Total: $ (estimate if necessary)

% of State Funds: % of Federal Funds: _____ % Other Funds:

**Please Specify source of Other Funds (Fees, Grants, etc.)

Date Contract Effective: Date Contract Ends:

Type of Contract: NEW: RENEWAL: AMENDMENT:

If renewal, was it originally Bid? Yes _____ No _____

If AMENDMENT, Complete A through C:

(A) Original contract total $

(B) Amended total prior to this amendment $

(C) Amended total after this amendment $

Was Contract secured through Bid Process? Yes ____ No ____ Was lowest Bid accepted? Yes ___
No____
Was Contract secured through RFP Process? Yes ____ No ___ **Date RFP was awarded** _____
Posted to Statewide RFP Database at http://rfp.alabama.gov/Login.aspx YES _____ No_____
If no, please give a brief explanation:

Summary of Contract Services to be Provided:

Why Contract Necessary AND why this service cannot be performed by merit employee:

I certify that the above information is correct.

_____ _____

Signature of Agency Head Signature of Contractor

_____ _____

Printed Name Printed Name

Agency Contact: Stephanie Lindsay Phone: (334) 242-5833
Revised: 2/20/2013

IMMIGRATION STATUS

I hereby attest that all workers on this project are either citizens of the United States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

_____
Signature of Contractor

_____
Witness

State of Alabama Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

(____)_____

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

Alabama Medicaid Agency

ADDRESS

501 Dexter Avenue, Post Office Box 5624

CITY, STATE, ZIP

Montgomery, Alabama 36103-5624

TELEPHONE NUMBER

(334) 242-5833

This form is provided with:

☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT RECEIVED	TYPE OF GOODS/SERVICES	AMOUNT

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE
DEPARTMENT/AGENCY		

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

ROBERT BENTLEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Acting Commissioner

MEMORANDUM

SUBJECT: Reporting to Ethics Commission by Persons Related to Agency Employees

Section 36-25-16(b) Code of Alabama (1975) provides that anyone who enters into a contract with a state agency for the sale of goods or services exceeding $7500 shall report to the State Ethics Commission the names of any adult child, parent, spouse, brother or sister employed by the agency.

Please review your situation for applicability of this statute. The address of the Alabama Ethics Commission is:

100 North Union Street
RSA Union Bldg.
Montgomery, Alabama 36104

A copy of the statute is reproduced below for your information. If you have any questions, please feel free to contact the Agency Office of General Counsel, at 242-5741.

Section 36-25-16. Reports by persons who are related to public officials or public employees and who represent persons before regulatory body or contract with state.

(a) When any citizen of the state or business with which he or she is associated represents for a fee any person before a regulatory body of the executive branch, he or she shall report to the commission the name of any adult child, parent, spouse, brother, or sister who is a public official or a public employee of that regulatory body of the executive branch.
(b) When any citizen of the State or business with which the person is associated enters into a contract for the sale of goods or services to the State of Alabama or any of its agencies or any county or municipality and any of their respective agencies in amounts exceeding seven thousand five hundred dollars ($7500) he or she shall report to the commission the names of any adult child, parent, spouse, brother, or sister who is a public official or public employee of the agency or department with whom the contract is made.
(c) This section shall not apply to any contract for the sale of goods or services awarded through a process of public notice and competitive bidding.
(d) Each regulatory body of the executive branch, or any agency of the State of Alabama shall be responsible for notifying citizens affected by this chapter of the requirements of this section. (Acts 1973, No. 1056, p. 1699, §15; Acts 1975, No. 130, §1; Acts 1995, No. 95-194, p. 269, §1.)

Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

(Derived from Appendix B to 45 CFR Part 76--Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions)

1. By signing and submitting this contract, the prospective lower tier participant is providing the certification set out therein.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Alabama Medicaid Agency (the Agency) may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the Agency if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, and voluntarily excluded, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this contract is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this contract that, should the contract be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this contract that it will include this certification clause without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier

covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the Agency may pursue available remedies, including suspension and/or debarment.

State of _____)

County of _____)

CERTIFICATE OF COMPLIANCE WITH THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535, as amended by Act 2012-491)

DATE:_____

RE Contract/Grant/Incentive (*describe by number or subject):* _____ by and between _____ (Contractor/Grantee) and Alabama Medicaid Agency (State Agency or Department or other Public Entity)

The undersigned hereby certifies to the State of Alabama as follows:

1. The undersigned holds the position of _____with the Contractor/Grantee named above, and is authorized to provide representations set out in this Certificate as the official and binding act of that entity, and has knowledge of the provisions of THE BEASON-HAMMON ALABAMA TAXPAYER AND CITIZEN PROTECTION ACT (ACT 2011-535 of the Alabama Legislature, as amended by Act 2012-491) which is described herein as "the Act".

2. Using the following definitions from Section 3 of the Act, select and initial either (a) or (b), below, to describe the Contractor/Grantee's business structure.

BUSINESS ENTITY. Any person or group of persons employing one or more persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood, whether for profit or not for profit. "Business entity" shall include, but not be limited to the following:

a. Self-employed individuals, business entities filing articles of incorporation, partnerships, limited partnerships, limited liability companies, foreign corporations, foreign limited partnerships, foreign limited liability companies authorized to transact business in this state, business trusts, and any business entity that registers with the Secretary of State.
b. Any business entity that possesses a business license, permit, certificate, approval, registration, charter, or similar form of authorization issued by the state, any business entity that is exempt by law from obtaining such a business license, and any business entity that is operating unlawfully without a business license.

EMPLOYER. Any person, firm, corporation, partnership, joint stock association, agent, manager, representative, foreman, or other person having control or custody of any employment, place of employment, or of any employee, including any person or entity employing any person for hire within the State of Alabama, including a public employer. This term shall not include the occupant of a household contracting with another person to perform casual domestic labor within the household.

_____*(a)*The Contractor/Grantee is a business entity or employer as those terms are defined in Section 3 of the Act.

_____*(b)*The Contractor/Grantee is not a business entity or employer as those terms are defined in Section 3 of the Act.

3. As of the date of this Certificate, Contractor/Grantee does not knowingly employ an unauthorized alien within the State of Alabama and hereafter it will not knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama;

4. Contractor /Grantee is enrolled in E-Verify unless it is not eligible to enroll because of the rules of that program or other factors beyond its control.

Certified this _____ day of _____ 20____. _____

Name of Contractor/Grantee/Recipient

By: _____

Its _____

The above Certification was signed in my presence by the person whose name appears above, on this _____ day of _____ 20_____.

WITNESS: _____

_____

Print Name of Witness